



# Workers Compensation Supplemental Application

Applicant Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Physical Address: \_\_\_\_\_

Please indicate any additional locations below:

Location 2: \_\_\_\_\_  
 Location 3: \_\_\_\_\_  
 Location 4: \_\_\_\_\_  
 Location 5: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Federal Employers Identification Number (FEIN): \_\_\_\_\_ Entity Type (Individual/Partnership/Corp/Other): \_\_\_\_\_  
 Number of Years in Business: \_\_\_\_\_ If less than 5 years, number of years experience in trade: \_\_\_\_\_

**OWNERS, OFFICERS & DIRECTORS:**

List each Owner, Officer and/or Director. If they wish to be included in coverage, please provide their class code and payroll.

	NAME	TITLE	Ownersh ip %	Excluded	INCLUDED (if included provide annual payroll)
A				<input type="checkbox"/>	<input type="checkbox"/> \$
B				<input type="checkbox"/>	<input type="checkbox"/> \$
C				<input type="checkbox"/>	<input type="checkbox"/> \$
D				<input type="checkbox"/>	<input type="checkbox"/> \$
E				<input type="checkbox"/>	<input type="checkbox"/> \$
F				<input type="checkbox"/>	<input type="checkbox"/> \$

Total = 100%

Please provide estimated annual payroll for the upcoming fiscal year. Please break the Payroll down by class of business, by location.

Classification: \_\_\_\_\_ Payroll \$ \_\_\_\_\_ # of employees: FT \_\_\_\_\_ PT \_\_\_\_\_ Location # \_\_\_\_\_  
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1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT? Yes No
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc). Yes No
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET? Yes No
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER? Yes No
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS? Yes No
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED). Yes No %
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.? Yes No
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION? Yes No
9. ANY GROUP TRANSPORTATION PROVIDED? Yes No
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE? Yes No
11. ANY SEASONAL EMPLOYEES? Yes No
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? Yes No
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS? Yes No
14. ARE ATHLETIC TEAMS SPONSORED? Yes No
15. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE? Yes No
16. ANY OTHER INSURANCE WITH THIS INSURER? Yes No
17. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)? Yes No
18. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY? Yes No
19. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? Yes No
20. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? Yes No
21. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS? Yes No
22. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITTY NAME(S) AND POLICY NUMBERS(S). Yes No



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X

X

X

Named Insured: _____		Web Address: _____	
Insured's FEIN: _____			
<b>Contact Name and Phone Number</b>			
Inspections: _____	( )	-	
Premium Audit: _____	( )	-	
Claims: _____	( )	-	
<b>Prior Payroll and Premium Information</b>			
	<u>Total Annual Payroll</u>		<u>Premium \$</u>
Current Year: _____	_____		_____
Prior Year: _____	_____		_____
Prior Year: _____	_____		_____
Prior Year: _____	_____		_____
<b>Operations and Benefits</b>			
Please provide a detailed description of the operation: _____			
Years in business? _____	Hours of operation- _____	to _____	# of Shifts - _____
Is there a driving/delivery exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Radius of operations/travel: <input type="checkbox"/> <50 miles <input type="checkbox"/> 50-100 <input type="checkbox"/> 100+		
If yes, what is frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other: _____	Any group transportation of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is a PUC/DMV filing required? <input type="checkbox"/> PUC <input type="checkbox"/> DMV <input type="checkbox"/> N/A			
Are vehicles company owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how provided? <input type="checkbox"/> car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus		
If yes, are vehicles taken home? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of employees transported per vehicle _____		
# Of vehicles? _____ # Of drivers? _____	# of vehicles used to transport _____		
Vehicle/fleet maintenance program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
If yes, who does the servicing? <input type="checkbox"/> Outside vendor <input type="checkbox"/> In-house mechanics <input type="checkbox"/> Other: _____			
Do employees use personal vehicles for company business? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do any employees work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any out of state, international or overnight (within state) travel? <input type="checkbox"/> Yes <input type="checkbox"/> No	List the # of employees who live or work out of state:		
If yes, please provide details -	_____ Live	_____ Work	
Why/purpose? _____			
Who will travel? _____			
Where? _____			
Duration? _____			
Frequency? _____			
# of employees: Full time _____ Part-time _____ Seasonal _____ Volunteers _____	(Verify number is consistent with the number on Acord App)		
# of W-2's issued – Last year _____ Previous year _____	How are employees paid? <input type="checkbox"/> Hourly		
Any day laborers or temporary/employee leasing? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Piece rate <input type="checkbox"/> Commission <input type="checkbox"/> Flat salary		
If yes, please provide details on separate page.	<input type="checkbox"/> Other: _____		
% of union employees _____ % of non-union _____	Paid Sick Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Actual average hourly wage for employees in governing class \$____/hour	Paid Vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Retirement / Pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does employer contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Group medical provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	% of employees enrolled _____		
If yes, name of healthcare provider - _____	% paid by employer _____		
Do you use a specific medical provider to treat injured employees? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you currently participating in a MPN (Medical Provider Network)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the name of current MPN: _____			
CPR training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	RTW Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
# of employees certified? _____	Does it include salary continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the ownership of the applicable entity changed within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details: _____			



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## Hiring Practices – Employee Selection - Claims

Written Application?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-hire drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reference Checks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Post Accident drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre/post employment Physicals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	MVR Checks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic back testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Audio hearing tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formal job descriptions on file?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a formal written accident report?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are personnel files documented for pre-existing injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there set procedures for reporting claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Average claim reporting time frame - _____		Any Interchange of labor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is job specific training provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain	<input type="checkbox"/> Another business <input type="checkbox"/> Subsidiary
Employee Orientation Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> between departments <input type="checkbox"/> Other: _____
If yes, is the orientation <input type="checkbox"/> Verbal only? <input type="checkbox"/> Verbal and Documented?			
Supervisor to Employee ratio - <input type="checkbox"/> Better than 4-1 <input type="checkbox"/> 5-1 <input type="checkbox"/> 6-1 <input type="checkbox"/> 7-1 <input type="checkbox"/> >7-1			
Subcontractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____			
If yes, are certificates of insurance obtained and kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Independent contractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____			
If yes, how are they paid? <input type="checkbox"/> 1099's? <input type="checkbox"/> Other? Please explain- _____			

## Safety Program and Organization – Work premises and Environment

Are owners active in daily operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are they excluded from coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Active injury & illness prevention program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has loss control services been performed in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Active safety incentive program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has Cal/OSHA visited or cited your business in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does it encompass all employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide explanation on separate page.	
What type of incentive? _____		Are safety meetings conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do employees receive safety training/orientation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	
If yes, is the training - <input type="checkbox"/> Formal / Documented <input type="checkbox"/> Informal		<input type="checkbox"/> Other: _____	
Do you have a safety director or risk manager?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name and title: _____	
If yes, is the position full time or an additional responsibility of another employee? _____			
MSDS (Material Safety Data Sheets) available for all chemicals and products used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
Any material handling exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____			
Any lifting exposures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Forklift training provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, <input type="checkbox"/> <25 lbs. <input type="checkbox"/> 25-40 <input type="checkbox"/> 40+		If yes, annual certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If 40+, manual lifting or with assistance? Please explain _____			
Is all machinery/equipment properly guarded?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Any use of Baler equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Written Lock out / tag out / block out procedures in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Condition of equipment? <input type="checkbox"/> New <input type="checkbox"/> Good <input type="checkbox"/> Average	
Respiratory program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Are all equipment operators trained/ certified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
What is the maximum height at which you will work? _____		Personal protection equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	



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What is used? <input type="checkbox"/> Ladder <input type="checkbox"/> Scaffolding <input type="checkbox"/> Scissor lifts <input type="checkbox"/> N/A	Personal protection equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If scaffolding used, does the insured build their own? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, strict enforcement of utilization? <input type="checkbox"/> Yes <input type="checkbox"/> No
Written Fall Protection Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	What types of PPE? _____
Is the building / premises - <input type="checkbox"/> Owned or <input type="checkbox"/> Leased?	# Of years at current location? _____
Condition of premises? <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Average	Age of building occupied? _____ year(s)

Note: All information provided is subject to verification by way of an underwriting survey or inspection. We must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.



Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



FOR WINERIES with Vineyards and/or Tasting Rooms:

- What is the size of the tanks? Please provide gallon size/capacity.
- Does the insured clean and maintain their tanks? If so, please describe how?
- Does the insured have a confined space program in place?- Please provide details?
- Is an oxygen wand used inside confined spaces?
- Does the ventilation system meet Osha requirements?
- Does the equipment include proper guarding?
- Does all equipment include safety posting notices?
- Does the insured conduct pre-season training safety on operating equipment?
- Confirm all forklift drivers are certified?
- Is any bottling performed by the insured, if yes, portable or permanent?
- If portable, does the insured bottle wine for others off-premise?
- Does the insured own a vineyard?
- How many employees does the insured have for this operation?
- Confirm the insured is not a Farm Labor Contractor or manages farms for others?
- Does the insured own an aircraft and or conduct aerial crop dusting?
- Is the harvesting conducted by insured? If so how is it processed; manual labor or mechanically?
- Does the insured haul crops for others? Is group transportation (> four employees in one vehicle) provided?
- Does the insured own vehicles with more than 8 passenger seats?
- Does the insured provide housing, if so how many employees?
- Does the insured own and operate any Quads, 2 or 3 wheel powered vehicles, if so describe.
- Does the insured have any table grapes acreage?
- Describe the controls in place for heat exposures
- Does the grape harvester have proper safe guards?
  
- Does the insured have a tasting room? If so, what are the hours of operation?
- Are the sales of alcohol/wine sold for consumption off-premise, more than 50% of gross receipts?
- Does the insured have any outside salespersons?
- Are salespeople for the insured considered independent contractors?
- Does the insured review MVRs for new hires and annually for employees who drive?
- What is the maximum manual weight that is being lifted by employees?





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Written Injury & Illness Prevention Program?  Yes  No

Written Heat Stress Program?  Yes  No

Special Written Procedures for working in Confined Spaces (Attics & Under Residences / Buildings)?  Yes  No

Documented New Employee Orientation including Documented Training?  Yes  No

### Public Entities

Municipality \_\_\_\_\_ County \_\_\_\_\_

Check each applicable operational department / category:

Water Department     Power Department     Sewer Department     Street / Road Department

Street Sweeping / Cleaning     Building Inspector     Code Enforcement     Garbage / Refuse / Recycling

Parks / Recreation     Landscape Maintenance     Tree Trimming     Waste Treatment

Housing Authority     Day Care / Child Care     Public Housing Nurse     Electricians

Painters     Mechanic     Truck Driver

Fire Department     Police Department     Animal Control

# F/T Staff \_\_\_\_\_ # P/T Staff \_\_\_\_\_

Any Volunteers or Intern Staff?  Yes  No If yes, explain \_\_\_\_\_

City Council Positions?  Yes  No # \_\_\_\_\_

County Supervisors Positions?  Yes  No # \_\_\_\_\_

Does the hiring process include: Drug Screening?  Yes  No Pre Employment Physicals?  Yes  No If yes, explain \_\_\_\_\_

Any Post Accident Drug Testing?  Yes  No

Is there a probationary period upon hire?  Yes  No If yes, explain \_\_\_\_\_

Are employees provided with any New Employee Orientation?  Yes  No

Does each job have a written job description?  Yes  No

Do employees receive initial job training?  Yes  No

Is training on-going and documented?  Yes  No

Do employees work shifts?  Yes  No If yes, explain \_\_\_\_\_

Any on-call employees?  Yes  No If yes, explain \_\_\_\_\_

Do any employees have take home vehicles?  Yes  No If yes, explain \_\_\_\_\_

Any underground work?  Yes  No If yes, explain \_\_\_\_\_

Any work above 12' in height?  Yes  No If yes, explain \_\_\_\_\_

Any confined space exposures?  Yes  No If yes, explain \_\_\_\_\_

If yes, is there a Written Confined Space Entry Program?  Yes  No

Any sub-contracted operations?  Yes  No If yes, explain \_\_\_\_\_

Are W / C Certificates of Insurance obtained on all sub-contractors?  Yes  No

Any use of independent contractors?  Yes  No If yes, explain \_\_\_\_\_

Number of vehicles? \_\_\_\_\_ Driving Radius? \_\_\_\_\_

Do employees use personal vehicle for business purposes?  Yes  No If yes, explain \_\_\_\_\_

### Restaurants

Entertainment provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bar or separate lounge area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fast Food?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any catering?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of: _____ Hosts _____ Waitpersons _____ Bartenders		If yes, radius of operations: _____ miles % of exposure - _____	
_____ Valet _____ Busboys _____ Cooks		Any delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No Delivery hours - _____ to _____	
Average price of entrée? <input type="checkbox"/> <\$5 <input type="checkbox"/> \$5-\$15 <input type="checkbox"/> \$15+		If yes, radius of operations: _____ miles % of exposure - _____	

Servicing, cleaning of hoods/filters/grease traps or related systems provided by:  Outside vendor  Employees

### Retail / Wholesale

Type of Merchandise? \_\_\_\_\_

Gross Receipts: Wholesale \_\_\_\_\_ % Retail \_\_\_\_\_ % Warehousing?  Yes  No

Any repacking or repackaging operations?  Yes  No

If yes, please explain operations: \_\_\_\_\_

Assembly exposure?  Yes  No



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If yes, please explain exposure: \_\_\_\_\_

Any distribution exposure?  Yes  No If yes, by common carrier or does insured have a trucking exposure? Please explain on separate page.

## Trucking

**Type of Authority:** a)  Common Carrier  Contract Carrier  Private  Brokerage  Exempt

b)  Regular Route  Irregular Route

**Carrier Operations:**  California Only  Interstate

Length of Haul with Total % = 100%:

Under 50 Miles _____ %	50 – 200 _____ %	201 – 300 _____ %
301 – 500 _____ %	501 – 1,000 _____ %	Over 1,000 _____ %

**Filings:** DOT# \_\_\_\_\_ PUC# \_\_\_\_\_ DMV/MCP# \_\_\_\_\_  Not Applicable

**Please Check the Questions and Attached the Applicable Data:**

Motor Carrier Identification Report, MCS-150:  Attached or  Not Applicable

Cargo Classification:  See attached MCS-150 or  See below (check all that apply):

- General Freight  Logs, Poles Beams, Lumber  Liquids/Gases  Grain, Feed, Hay  Chemicals
- Household Goods  Building Materials  Intermodal Containers  Coal, Coke  Commodities Dry Bullion
- Metal Sheets, Coils, Rolls  Mobile Homes  Passengers  Meat  Refrigerated Food
- Motor Vehicles  Machinery, Large Objects  Oilfield Equipment  Garbage, Refuse, Trash  Beverages
- Driveway/Towaway  Fresh Produce  Livestock  U.S. Mail  Paper Products
- Other \_\_\_\_\_

**Drivers:** a) Number of Drivers \_\_\_\_\_ b) Number of Owner/Operators used \_\_\_\_\_

- Percentage where the Motor Carrier will provide workers' compensation for the Owner/Operators \_\_\_\_\_ %

- Percentage where the Motor Carrier will agree with the Owner/Operator that the Owner/Operator

assumes the responsibilities of an Employer for the performance of work: \_\_\_\_\_ %

c) If Owner/Operators used, please attach copy of contract:  Attached or  Not Applicable

d) Number of company drivers with Motor Carrier at least 12 months: \_\_\_\_\_

Number of Owner/Operator with Motor Carrier at least 12 months: \_\_\_\_\_ or  Not Applicable

e) Number of Non-Union: \_\_\_\_\_ Union: \_\_\_\_\_

f) Do the drivers load and unload their trucks?  No  Yes (please provide detail of the types of materials loaded/unloaded

and any equipment used: \_\_\_\_\_

Is the applicant enrolled in the DMV Pull Program?  Yes  No If so, how often? \_\_\_\_\_

Is the applicant enrolled in the CHP BIT Program?  Yes  No

Total # of Trucks \_\_\_\_\_ # of Trucks with Sleeper Cabs \_\_\_\_\_ Single Trailers \_\_\_\_\_ Double Trailers \_\_\_\_\_ Triple Trailers \_\_\_\_\_

Any trucks / trailers with ramps?  Yes  No If yes, please provide # \_\_\_\_\_

Any trucks / trailers with lift-gates?  Yes  No If yes, please provide # \_\_\_\_\_

Any team driver operations?  Yes  No If yes, please provide details- \_\_\_\_\_

If union operations, provide Month / Year of contract renewal: \_\_\_\_\_