

Workers' Compensation Healthcare Supplemental Application

(To be Completed with Acord 130 application)



Insured: _____

Web Site: _____

Detailed Description of Operations:

Type of Facility: Social Medical Behavioral Health Therapy

Number of Years in Business: _____ How Long Under Current Management: _____
 Are Owners Active in Daily Operations: Yes No If Yes, Are They Excluded From Coverage: Yes No

Number of Full Time Employees _____ Number of Part Time Employees: _____
 Hours of Operation: _____ to _____ Number of Shifts: _____ Number of Days per Week: _____
 Are There Greater Than 10 Employees in Any One Location at Any One Time: Yes No

If Yes, Complete EE Concentration Survey (Page 3)

Annual Turnover Rate: Professional _____ Non-professional _____
 Average Employee Tenure (Years): Professional _____ Non-professional _____

Is There Janitorial Exposure: Y N If Yes, Are Duties Performed By Employees Subcontractors
 Is There Food Preparation Exposure: Y N If Yes, Are Duties Performed By Employees Subcontractors

Patient-To-Nurse Ratio (Staff-To-Client Ratio): _____

Explain all "Yes" responses to the following questions on a separate sheet of paper

Does the Applicant Own (Or Is Affiliated With) Any Business Other Than This Submission Yes No
 Has the Insured Had Any OSHA Citations in the Last Five Years Yes No
 Has There Been a Change in the Administrator/Director of Nursing Position within the Past year Yes No

Year	Total Annual Payroll	Premium
Expiring Year		
1 st Prior Year		
2 nd Prior Year		
3 rd Prior Year		
4 th Prior Year		

Hiring Practices:

Written Applications Yes No Pre/Post Employment Physical Yes No
 In Person Interviews Yes No Orthopedic Back Screening Yes No
 Criminal Background Checks Yes No Motor Vehicle Record Check Yes No
 Validate Work History Yes No Temporary Labor Used Yes No
 Pre-Hire Drug Testing Yes No Volunteer Labor Used Yes No

Does Insured Intend To Cover Non-compensated Volunteer Employees, If Allowed By Their State? Yes No
 If Yes, Provide Number of Volunteers, Description of Duties, Total Annual Hours Worked On a Separate Sheet Of Paper.

Volunteers shall be classified and rated in accordance with the appropriate classification or classifications usual to paid employees engaged in similar occupations. If payroll or remunerations is not determinable, minimum wage may be used.

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Safety Programs / Employee Training:

New Hire Orientation Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Employee Safety Training	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Written Job Description	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Safety Incentive Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Job Specific Training	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Return to Work Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Designated Full Time Safety Director	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Safety Committee	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Safety Meetings Held for All Employees	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
<i>If Yes, How Often</i> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annual <input type="checkbox"/>					
Supervisors Are Held Accountable for Injuries/Accidents	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Slip / Fall Prevention Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Hazardous Materials Communication Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Blood-borne Pathogen Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Care of Aggressive/Combative Patients Training	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Personal Protection Equipment Provided	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
<i>If Yes, Is Strict Enforcement of Utilization Enforced</i> Yes <input type="checkbox"/> No <input type="checkbox"/>					
Patient Handling/Lifting Protocols	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Does the Facility Utilize Lifting Devices	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
<i>If Yes, Are There Consequences for Failure to Use Lifts Explained in the Employee Handbook</i> Yes <input type="checkbox"/> No <input type="checkbox"/>					

Post Lost Practices:

Post Accident Drug Testing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Injured Workers Are Treated Onsite	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Accident Investigation Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>	All Injuries Are Reported to Your Carrier	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Average length of time it takes to report a claim to your carrier _____					

Vehicle / Driving Exposure:

Is There Driving / Delivery Exposure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(If Yes, Complete Questions Below)
Any Group Transportation of Employees	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Description of Driving Exposure _____

Number of Vehicles _____ Number of Drivers _____

Are Vehicles Company Owned	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do Employees Use Personal Vehicles for Company Business	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are Employees Allowed to Keep Company Autos at Their Home	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are Motor Vehicle Records Reviewed Annually for All Employees Who Drive as Part of Their Job	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is There a Vehicle / Fleet Maintenance Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is Driver Training Conducted	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Average Number of Visits per Month	_____	Radius of Travel for Company Vehicles	_____
Average Number of Miles Traveled Per Month	_____	Percent of Travel Exceeding 100 Mile Radius	_____

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. It is a crime to knowingly provide false, incomplete or misleading information to any party to a Workers Compensation transaction for the purpose of committing fraud. Penalties include imprisonment and fines, and may also include denial of insurance benefits. (Not applicable in OR) Applicable in CO: Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature of Applicant _____ Date _____

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Employee Concentration/Terrorism - Questionnaire

Required Information for every Physical Location with 10 Employees in Any One Location at Any One Time

Street Address	City	State	Total WC Payroll	Total # of EE's Assigned To Location	Max # of EE's On Site At Any One Time	If > 10 ee's		If > 100 ee's		
						# of Stories In Bldg.	If > 10 Stories: Highest Floor Occupied	Building Construction	Year Built	Sprinklered? (y / n)
								Code 1		No
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes
								Code 1		Yes

Building Construction Type:

Frame (Code 1)

Joisted Masonry (Code 2)

Non-combustible (Code 3)

Masonry non-combustible (Code 4)

Modified fire resistive (Code 5)

Fire Resistive (Code 6)

Total # of employees assigned to location:

The number of employees that work at each location, excluding independent contractors or contract employees unless the customer is responsible for the WC insurance.

Max # of employees on site at any one time:

The largest number of employees likely to be on site at any one time. For locations that work multiple shifts, this would be the count for the shift with the most workers. Exceptions - this value should not include the following:

- Employees visiting the location for periodic meetings (e.g. quarterly and annual sales meetings);
- Shift overlaps of less than thirty minutes (just record the largest shift, not both);
- Temporary headcount changes due to seasonal fluctuations as long as the increase/decrease occurs for less than two months during the policy year;
- Employees who are constantly traveling from place to place (e.g., drivers, visiting nurses, outside sales people, construction supervisors), and are not present at an insured location for more than eight hours per week.