**COMMUNITY SERVICES WORKERS COMPENSATION**

**SUPPLEMENTAL APPLICATION**

**Instructions:** Please answer all questions. If the answer is none, state none. If the answer is not applicable, state N/A. If the space provided is insufficient to fully answer the question, please attach a separate sheet. Application must be dated and signed by owner, partner, officer, or administrator of the First Named Insured.

|  |  |
| --- | --- |
| First Named Insured: |       |
| Application Completed By: |       |
| Job Title: |       | Website URL: |       |

1. **EMPLOYEE INFORMATION**

Please include uninsured subcontractors and/or 1099 employees. Note that amounts paid to uninsured subcontractors and/or 1099 employees are captured as remuneration for premium computation purposes.

|  |  |
| --- | --- |
| 1. Describe operations:
 |       |
|  |       |
| 1. Indicate estimated percentage of annual employee turnover:
 |       |

| 1. Indicate:
 | Total Number of Each | Percentage of Workforce | Job Duties |
| --- | --- | --- | --- |
| Employees under 60 |       |       |       |
| Volunteers |       |       |       |

| 1. Indicate:
 | Total Number of Each | Annual Payroll | Type of Work Subcontracted | Do they carry their own WC insurance?\* |
| --- | --- | --- | --- | --- |
| Independent Contractors |       |       |       | [ ]  Yes [ ]  No |
| Leased/Temporary Employees |       |       |       | [ ]  Yes [ ]  No |

|  |  |
| --- | --- |
| \*If Yes, are certificates of insurance obtained and kept on file? |  [ ]  Yes [ ]  No |
| 1. Indicate the number of leased or temporary workers Applicant provides to any other companies:
 |       |  [ ]  None |
| 1. In reference to **5.** above, indicate which party is responsible for providing workers compensation:
 |
|  |       |
| 1. Please indicate:
 |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Occupation | # Full Time | # Part Time | Part Time Avg Hours/Week | Avg Hourly Wage | % of employees that are 1099 |
| Licensed Practical Nurses |       |       |       |       |       |
| Nurse Practitioners |       |       |       |       |       |
| Occupational Therapists |       |       |       |       |       |
| Registered Nurses |       |       |       |       |       |
| Housekeeping |       |       |       |       |       |
| Maintenance |       |       |       |       |       |
| Kitchen Staff |       |       |       |       |       |
| Office / Administrative |       |       |       |       |       |
| Management |       |       |       |       |       |
| Non Professional |       |       |       |       |       |
| Other |       |       |       |       |       |

1. **HIRING AND EMPLOYMENT PRACTICES**

|  |  |
| --- | --- |
| 1. Does the Application process include (check all that apply):
 |  |
| [ ]  Written application  | [ ]  References checked | [ ]  Personal interviews |
| [ ]  Pre-hire and/or annual medical screening? |  |
| 1. Does Applicant require documentation of pre-existing injuries?
 | [ ]  Yes [ ]  No |
| 1. Does Applicant provide a return to work program?
 | [ ]  Yes [ ]  No |
|  If Yes, describe return to work program (or attach a copy): |       |
| 1. Does Applicant provide a (check all that apply):
 |  |
| [ ]  Drug/alcohol rehabilitation program | [ ]  New hire training/orientation program |
| [ ]  Drug Free Workplace program | [ ]  Formal job descriptions |
| 1. Does Applicant (check all that apply):
 |  |
| [ ]  Provide written personnel procedures | [ ]  Require criminal background checks (federal and state) |

1. **LOSS CONTROL AND SAFETY**

|  |  |
| --- | --- |
| 1. Is Applicant’s risk manager/safety director: [ ]  Full time [ ]  Part time [ ]  No Risk Manager
 |  |
| 1. Indicate name and title of person(s) responsible for safety:
 |       |
| 1. Does Applicant have a (check all that apply):
 |  |
| [ ]  Formal safety committee | [ ]  Accident review program |  |
| [ ]  Written safety program | [ ]  Violent incident reporting program |  |
| [ ]  Hazard identification program | [ ]  Blood borne pathogen program |  |
| [ ]  Formal and enforced lifting policy | [ ]  Written post-incident response procedures |  |
| 1. Does Applicant have a safety incentive program?
 | [ ]  Yes [ ]  No |
|  If Yes, describe: |       |
|  If Yes, is the safety program OSHA approved? | [ ]  Yes [ ]  No |
| 1. Does Applicant hold safety meetings/training regularly with employees?
 | [ ]  Yes [ ]  No |
| If Yes, how often? [ ]  Weekly [ ]  Monthly [ ]  Quarterly [ ]  Semi-annually |  |
| 1. Is an intake evaluation performed for all new clients/residents?
 | [ ]  Yes [ ]  No |
| 1. What is the maximum weight employees are required to lift (in pounds)?
 |       |
| 1. Is Applicant willing to implement loss control recommendations made by the insurer?
 | [ ]  Yes [ ]  No |
| 1. Is Applicant willing to utilize C&F’s medical provider network (MPN, HCN, HCO)?
 | [ ]  Yes [ ]  No |
| 1. Describe personal protective equipment used:
 |       |

1. **FIXED LOCATION EMPLOYEES**

|  |
| --- |
| In the chart below, enter the data only for employees who work in the same building or fixed location for the majority of the working day.  |
| **Location** **#** | **Building Construction**  | **Year Built** | **# of stories** | **# of floor(s) occupied** | **Total # of employees** **F/T P/T** | **# of shifts** | **Maximum # of employees per shift** |
| 1 |       |       |       |       |       |       |       |
| 2 |       |       |       |       |       |       |       |
| 3 |       |       |       |       |       |       |       |
| Note: If additional locations, please include on a separate page. |

1. **MOBILE EMPLOYEES**

|  |
| --- |
| In the chart below, enter the data only for employees who regularly travel to client locations or job sites, such as home health care workers, drivers or others who provide offsite services and are rarely at the Applicant’s street location. |
| **State** | **Class Code** | **Class Code Description** | **Payroll** | **Total # of employees** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

1. **BENEFITS**

|  |  |
| --- | --- |
| 1. Does Applicant provide Group Medical insurance?
 | [ ]  Yes [ ]  No |
| 1. If Yes, indicate: [ ]  Full time [ ]  All employees, including part time
 |  |
| 1. If Yes, what percentage is paid by employer?
 |       |
| 1. If Yes, what is the percentage of participating employees?
 |       |
| 1. Does Applicant provide (check all that apply): [ ]  Disability insurance [ ]  Paid Sick Days

 [ ]  Paid Vacation Time |

1. **VEHICLE AND DRIVING EXPOSURES**

|  |  |
| --- | --- |
| 1. Indicate total number of employees that drive on company business:
 |       |
| 1. Indicate number of regular drivers of company vehicles:
 |       |
| 1. Indicate number of employees who regularly drive their own vehicles on company business:
 |       |
| 1. How often are employees required to transport patients?
 |       | [ ]  N/A |
| 1. Motor Vehicle Records are checked for all employees who may drive between facilities or run errands:
 |
| [ ]  At Hire and every:  |       | years thereafter [ ]  MVRs are not checked |
| 1. Does Applicant obtain copies of drivers’ licenses for all employees, ICs and volunteers?
 | [ ]  Yes [ ]  No |
| 1. Employees that drive are held to the following MVR standards:
 |  |
| [ ]  No more than: |       | Minor violations and at fault accidents (combined) in a 3 year period |
| [ ]  No more than: |       | Major violations (DUI, reckless, eluding, felony, etc.) in a 5 year period |
| [ ]  No violations in the last three years |
| 1. Does the Applicant (check all that apply):
 |  |
| [ ]  Enforce a seat belt policy? |  [ ]  Have a written driver alcohol/drug use policy? |
| [ ]  Have a written distracted driver policy? |  [ ]  Have a written driver safety program in place? |
| [ ]  Utilize vehicle preventative maintenance checks? |
| [ ]  Have a written plan to deal with employees who have poor driving records? |  |
| 1. Radius of operations:
 |       | % < 50 miles |       | % 50-100 miles |       | % 100+ miles |
| 1. Are employees trained in passenger assistance?
 | [ ]  Yes [ ]  No |

1. **REQUIRED ATTACHMENTS**

Please include the following information with your submission. All are required prior to bind:

1. Loss history for the current and five prior complete policy years along with corresponding loss runs. For claims over $25,000, please advise us of the following: Was it an accepted claim? Is the employee still working for the insured? What corrective action has the insured taken to prevent reoccurrence? How did it occur? What was the injury?
2. Copy of most recent experience modification worksheet available
3. General Application **NP 16 001,** or Acord 130 and Crum and Forster Warranty Statement.

**FRAUD NOTICE**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (Not applicable in AL, AR, CO, DC, FL, KS, KY, LA, MD, ME, NJ, NM, NY, OH, OK, OR, RI, TN, VA, VT, WA or WV – see Additional Fraud Notices for these States below).

**NOTICE TO APPLICANT – PLEASE READ CAREFULLY**

For the purpose of this application, the undersigned applicant declares that, to the best of his or her knowledge, the statements herein are true and complete. The Insurer is authorized to make any inquiry in connection with this application. Signing this application does not bind the Insurer to issue, or the applicant to purchase, any insurance policy.

The information contained in and submitted with this application is on file with the Insurer. This application will become a part of such policy if issued. The Insurer will have relied upon this application and attachments (if any) in issuing this policy.

If the information in this application materially changes prior to the effective date of the policy, the applicant must notify the Insurer, who may modify or withdraw the quote.

### SIGNATURES

|  |
| --- |
|  |
|  |  |  |       |  |  |  |       |  |
|  | Applicant’s Signature |  | Date |  | Producer’s Signature |  | Date |  |
|  |  |  |  |  |       |  |  |  |
|  | Print or type applicant’s name |  |  | Applicant’s Title |  |  |  |
|  |

### ADDITIONAL FRAUD NOTICES

**NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO COLORADO APPLICANTS:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. 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.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**NOTICE TO KANSAS APPLICANTS:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**NOTICE TO MAINE APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW YORK APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**NOTICE TO VERMONT APPLICANTS:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The undersigned declares that to the best of his or her knowledge and belief the statements and representations made herein and in any attachments appended hereto and/or incorporated herein by reference are true and complete and that no material facts have been misstated, misrepresented, suppressed or concealed. The signing of this application does not bind the undersigned to purchase insurance, nor does review of the application bind any insurer to issue a policy. It is agreed, however, that this application shall be the basis of the contract should a policy be issued. If there is any material change in the answers to the questions provided herein or in any of the attachments appended hereto and/or incorporated herein by reference prior to the effective date of the insurance policy, the applicant must immediately notify the insurer in writing and the insurer reserves the right in such instance to modify or withdraw any quotation or binder that may have been issued. The undersigned also represents that he or she is authorized on behalf of the applicant to complete and sign this application on its behalf.