

# NEGLEY ASSOCIATES

UNDERWRITING MANAGERS

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## Supplemental Workers' Compensation Application

**Named Insured:** \_\_\_\_\_ **Website:** \_\_\_\_\_

Policy Year	Policy Period	Premium	Total Audited Payroll	Insurance Carrier	Experience Mod
Expiring Year					
1 <sup>st</sup> Prior Year					
2 <sup>nd</sup> Prior Year					
3 <sup>rd</sup> Prior Year					
4 <sup>th</sup> Prior Year					

Number of Employees: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Temporary \_\_\_\_\_

Number of Volunteers: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Seasonal \_\_\_\_\_

Briefly describe volunteer's responsibilities: \_\_\_\_\_

**Are there greater than 100 employees in any one location?** Yes  No

If you answered "yes", please complete the following table:

Instructions: For each location, list the number of Floors for each location and the # of employees for each floor as well as for the entire location  
(Please write here or attach schedule.)

Location #	Description & Address of Property	# of Stories	Payroll	Number of Employees
1	Example Property	5	\$1,000,000	50 per floor; or 10- floor 1, 20- Floor 2, etc.

### General Information

Explain all "yes" responses (attach separate sheet if necessary)	YES	NO	Explain all "yes" responses (attach separate sheet if necessary)	YES	NO
a. Has there been a name change or a consolidation, merger or other ownership change during the past three years?  If yes, attach a separate signed ownership statement on employer's percentage of stock, and date of change.	<input type="checkbox"/>	<input type="checkbox"/>	b. Do you or any commonly owned or managed enterprises owe any unpaid workers compensation insurance premiums?	<input type="checkbox"/>	<input type="checkbox"/>
c. Has any owner ever been in business under a different name?  If yes, give name(s) and date(s) of operation.	<input type="checkbox"/>	<input type="checkbox"/>	d. Has any insurance company ever canceled your workers compensation policy for nonpayment or for any other reason?	<input type="checkbox"/>	<input type="checkbox"/>
e. Has any owner filed for bankruptcy?  If yes, give date and state of filing.	<input type="checkbox"/>	<input type="checkbox"/>	f. Is there any USL&H or other similar federal exposures?	<input type="checkbox"/>	<input type="checkbox"/>

**Hiring Practices and Benefits Information:**

	YES	NO		YES	NO
Are written applications used?	<input type="checkbox"/>	<input type="checkbox"/>	Do you do drug screening (check those that apply):		
Are reference checks performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> All-Employees <input type="checkbox"/> Drivers only <input type="checkbox"/> None		
Are employees who perform repetitive motion duties rotated throughout the day?	<input type="checkbox"/>	<input type="checkbox"/>	Is group medical coverage provided?	<input type="checkbox"/>	<input type="checkbox"/>
Does the insured use temporary workers?	<input type="checkbox"/>	<input type="checkbox"/>	Are employees provided paid sick leave?	<input type="checkbox"/>	<input type="checkbox"/>
Name of WC carrier for the temp. firm? _____			Paid vacation?	<input type="checkbox"/>	<input type="checkbox"/>

**Management and Safety Practices:**

	YES	NO	
Do you have a formal safety program?	<input type="checkbox"/>	<input type="checkbox"/>	
Are safety meetings or training provided?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other
			Composed of <input type="checkbox"/> Management <input type="checkbox"/> Supervisors <input type="checkbox"/> Workers
Do you perform routine safety inspections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
Do you have a Safety Incentive Program?	<input type="checkbox"/>	<input type="checkbox"/>	
Are safety issues communicated to employees?	<input type="checkbox"/>	<input type="checkbox"/>	Method _____
Are supervisors accountable for employee safety?	<input type="checkbox"/>	<input type="checkbox"/>	
Are accident investigations performed?	<input type="checkbox"/>	<input type="checkbox"/>	By <input type="checkbox"/> Executive Director <input type="checkbox"/> Safety Director <input type="checkbox"/> Owner <input type="checkbox"/> Other
Does the insured have lock out / tag out procedures?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use any mechanical lifting devices?	<input type="checkbox"/>	<input type="checkbox"/>	Description _____
Is the use of personal protective equipment enforced?	<input type="checkbox"/>	<input type="checkbox"/>	Description _____
Do you have a designated medical provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physician <input type="checkbox"/> Clinic <input type="checkbox"/> Other
Has your medical provider reviewed operations to assist with early return to work program?	<input type="checkbox"/>	<input type="checkbox"/>	

**RISK MANAGEMENT INFORMATION**

- a. Are independent contractors required to carry their own liability and workers' compensation insurance?  Yes  No
- b. Are copies of the insurance certificates obtained annually and kept on file?  Yes  No
- c. Does work performed by uninsured contractors exceed 15% of the receipts?  Yes  No
- d. If the insured has a formal safety program in operation please indicate applicable safety elements in 'e' below
- e. Please indicate which of the following **safety program elements** are currently operational:
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Driver Safety Program                                  | <input type="checkbox"/> Labor/Management Safety Committee      | <input type="checkbox"/> Return to Work/Modified Duty    |
| <input type="checkbox"/> Patient Handling/Transfer Training                     | <input type="checkbox"/> Mentoring process for new employees    | <input type="checkbox"/> Screening process for new hires |
| <input type="checkbox"/> New Employee Orientation                               | <input type="checkbox"/> Personnel Evaluations include "safety" | <input type="checkbox"/> Driver Training/Travel Logs     |
| <input type="checkbox"/> Management Involvement in safety (describe if checked) |   |  |
- \_\_\_\_\_
- \_\_\_\_\_

**Vehicle / Driving Exposure:**

			YES	NO
Do you provide <b>group</b> transportation for clients or employees? (If yes, please complete questions below)			<input type="checkbox"/>	<input type="checkbox"/>
Number of Clients _____	Number of Daily Trips _____	Purpose of Transportation _____		
Number of Employees _____	Number of Daily Trips (employees only) _____			
Do employees transport clients in personal or company cars during the workday? If yes, how often _____			<input type="checkbox"/>	<input type="checkbox"/>
And what is the purpose of the transportation? _____				
Are Motor Vehicle Records (MVR) checked annually for all employees who drive as part of their job?			<input type="checkbox"/>	<input type="checkbox"/>
Number of Company Vehicles _____		Delivery Provided	<input type="checkbox"/>	<input type="checkbox"/>
Number of Company authorized drivers _____		Participate in DMV "Pull" Program	<input type="checkbox"/>	<input type="checkbox"/>
Radius of Travel for Company Vehicles _____	Miles _____	Vehicle and Equipment Inspected: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Vehicles and Equipment Serviced By	<input type="checkbox"/> Employees <input type="checkbox"/> Outside Mechanics			

