

**CONTRACTOR'S INSURANCE CHOICE
WORKER'S COMPENSATION SUPPLEMENTAL APPLICATION**

GENERAL INFORMATION

Company Name: <CUST.INS.NAME> _____
Insured's Federal Tax ID Number: _____
Insured's Worker's Compensation Insurance Rating Bureau Number (WCIRB#): _____
Number of years in business: _____ years. If less than 4 years, number of years in the Trade: _____
Is the owner active in the business: yes () no () Duties performed: _____

Describe operations of the insured: _____

Percentage of work Interior _____ % Exterior _____ % Ext. over 3 stories _____ % Over 5 stories _____ %

BENEFITS

Does insured provide Group Medical? yes () no (), Employer contribution: _____ %
What percentage of employees are covered by the plan: _____ %
Waiting period: 30 days () 60 days () 90 days () Other: _____
Name of Group Medical provider: _____
Who is eligible? All employees () Only full-time () Other: _____
Does insured provide Life Insurance? yes () no (), if yes, Employer Contribution: _____ %
Does insured provide Disability Insurance? yes () no (), if yes, Employer Contribution: _____ %
Paid Vacation: yes () no () Paid Sick Leave: yes () no () 401K Profit Sharing: yes () no ()

MANAGEMENT

Does insured have a Return to Work program: yes () no (), with full pay: yes () no ()
Does insured have a return to full time Modified Duty work plan: yes () no ()
Is the Insured willing to implement Safety Recommendations made by the carrier: yes () no ()
Is the Insured willing to implement Loss Control Recommendations made by the carrier: yes () no ()
Additional Comments: _____

OPERATIONS

Hours of operation _____ to _____ Number of days per week: _____ Number of shifts: _____
Percentage of New Construction: Residential _____ % Commercial _____ % Industrial _____ %
Percentage of Remodeling: Residential _____ % Commercial _____ % Industrial _____ %
Percentage of Repair work: Residential _____ % Commercial _____ % Industrial _____ %
Percentage of Work Subcontracted: _____ %
Are deliveries made: yes () no () Frequency: Daily () Weekly () Other ()
Delivery radius: Under 50 miles () 50-100 miles () Over 100 miles ()
Vehicles owned: yes () no () Are vehicles taken home: yes () no ()
Vehicles maintenance program: yes () no () MVR "pull" program: yes () no ()
Any changes in Operations in the last 5 years: yes () no () if yes, describe: _____

PREMISES

Housekeeping / Cleanliness at the Jobsite: Excellent () Good () Poor ()
Condition of Equipment: Excellent () Good () Poor ()
Proper Safeguards utilized at the Jobsite: yes () no ()
Any Jobsite Security provided: yes () no () if yes, describe: _____
Additional Comments: _____

HIRING PRACTICES

Complete written applications: yes () no () Pathogenic test (i.e. lead): yes () no ()
Reference checks: yes () no () Audio testing: yes () no ()
Pre/Post employment physicals: yes () no () Orthopedic back test: yes () no ()
Drug/Substance abuse tests: yes () no () MVR's checked: yes () no ()
How are potential new employees hired (check all that apply):
Referrals () Word of Mouth () New Paper Ads ()
Recruiters () Union Hall () Other () describe: _____

EMPLOYEES

Number of employees: Full Time: _____ Part time: _____ Seasonal: _____
Employee turnover is: low () average () high ()
What is the hourly wage of the governing class of employees: \$ _____ per hour.
Do Employees utilize any Safety Protection: yes () no () describe: _____
Do Employees travel out of state on business: yes () no () if yes, number of employees: _____
Number of employees are: Increasing: _____ Stable: _____ Decreasing: _____

SAFETY

Person responsible for safety: _____ Phone # () _____
Does insured use a specific Medical Provider to treat injured employees: yes () no ()
Clinic () Physician () Emergency room () Other: _____
Written Safety Program (SB198): yes () no () Safety Incentive Program: yes () no ()
Full time Safety Director: yes () no () Part time (less 50%) yes () no ()
Safety / Tailgate meetings conducted for all employees: yes () no () How often: _____
Safety training program in place for employees: yes () no ()
Equipment Safeguards utilized: yes () no () describe: _____
Equipment Inspection / Maintenance program: yes () no () if yes, describe: _____

Slip & Fall Prevention program in place: yes () no ()
Hazardous Materials Communication program in place: yes () no ()
Lock Out / Tag Out program in place: yes () no ()
Confined Space program in place: yes () no ()
Industrial Truck / Vehicle program in place: yes () no ()
Violence intervention program: yes () no ()
Drug / alcohol awareness program: yes () no ()
First Aid Kit kept at the Jobsite: yes () no ()
Any Employees trained in First Aid: yes () no ()
Any Employees trained in CPR: yes () no ()

PAYROLL/PREMIUM INFORMATION

Provide total payrolls and premiums for the current and past Policy Periods.
2001-2002 Payroll \$ _____ /Premium \$ _____
2000-2001 Payroll \$ _____ /Premium \$ _____
1999-2000 Payroll \$ _____ /Premium \$ _____
1998-1999 Payroll \$ _____ /Premium \$ _____
1997-1998 Payroll \$ _____ /Premium \$ _____

BROKERS INFORMATION

Does this broker currently control the workers' compensation? yes () no () if yes, how many years _____

Signature of Applicant

Date