ICW GROUP
Insurance Companies

Workers' Comp
Earthquake
Surety
Auto

Workers' Compensation Supplemental Application

Named Insured: ______________________
Website: ______________________
Agency/Broker: ______________________

Does your agency currently control the account ☐ **Yes** ☐ **No**

If you need additional space for any answer, please use the comments section at the end of the supplemental or on a separate sheet of paper.

Operations/Exposures

Detailed Description of Operations: _____

1. Any seasonal operations? ☐ No ☐ Yes If yes, please explain _____
2. Operations are: ☐ Increasing ☐ Decreasing ☐ Stable
3. # of employees is: ☐ Increasing ☐ Decreasing ☐ Stable
4. Payrolls are: ☐ Increasing ☐ Decreasing ☐ Stable
   Please provide details for any previous or planned fluctuation in payroll. ______________________
5. Percent of union employees _____%
   Percent of non-union employees _____%
6. Turnover % for the last 12 months _____%
   Number of W-2's issued last year _____ Prior Year _____
   Future layoffs foreseen? ☐ No ☐ Yes
7. Number of employees: Full time _____ Part-time _____
   Seasonal _____ Volunteers _____

   Number of W-2's issued last year _____ Previous year _____
8. Employees are paid? ☐ Hourly ☐ Piece rate
   ☐ Commission ☐ Flat salary
   ☐ Other: _____
   If hourly: Average Wage/Hour $_____
9. Do any employees work from home? ☐ No ☐ Yes if yes, how many? _____
   What are their duties? ______________________
10. Average length of employment _____ Average number of years of experience _____
    Ratio of supervisors to employees _____ Average supervisor length of employment _____
    Average supervisor years of experience _____

11. Number of employees who live/work out of state: Live _____ Work _____
    What States: ______________________
12. Hours of operation: ☐ 24 Hours a day OR
    FROM _____________ ☐AM ☐PM TO _____________ ☐AM ☐PM

FROM ______________ ☐AM ☐PM TO ______________ ☐AM ☐PM
Number of shifts _____
Any weekend, nightshifts, or graveyard shifts? ☐ No ☐ Yes If yes, please explain ___________________
____
Any day laborers, temps or leased employees? ☐ No ☐ Yes If yes, please provide details______________
____

13. Any off-premises operations? ☐ No ☐ Yes if yes, what percentage _____%
If yes, please describe these operations ____
14. Independent contractors used? ☐ No ☐ Yes If yes, for what purpose ____________________________
If yes, how are they paid? ☐ 1099's ☐ Other (please explain)______________________________________
15. Are you currently participating in a MPN (Medical Provider Network)? ☐ No ☐ Yes
If yes, please provide the name of the current MPN:____
16. Has the ownership of the applicable entity changed within the past 5 years? ☐ No ☐ Yes
If yes above, please provide details (on another sheet if needed) _______________________________________
____
17. Does the insured belong to any trade associations? ☐ No ☐ Yes If yes, please list them _________________
____
18. Any group transportation of employees? ☐ No ☐ Yes
If yes above, how are employees transported?
☐ Car ☐Truck ☐ Van ☐ Bus ☐Other: _____
Number of employees' in a vehicle? _____
Number of vehicles used to transport? _____
How frequently are employees transported? _____

Premium/ Payroll

Please use estimated premium and payroll for the current policy and audited premium and payroll for all prior periods. Please provide payroll and premium going back at least 4 full years.

	Premium	Payroll
Current policy	$___________________	$___________________
1st Prior policy period	$___________________	$___________________
2nd Prior policy period	$___________________	$___________________
3rd Prior policy period	$___________________	$___________________
4th Prior policy period	$___________________	$___________________

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Please explain reason(s) for any lapses in coverage or policies greater than or less than a full year

Safety Program

1. Formal safety / injury & illness prevention program? ☐ No ☐ Yes
2. Is there a full-time safety director or risk manager, i.e. no additional job responsibilities? ☐ No ☐ Yes
   If yes, how long has there been a designated safety person? _____
   If yes, name and title:_________________
3. Active safety incentive program? ☐ No ☐ Yes
   If yes, what type of incentive(s)?_________________
   If yes, does it encompass all employees? ☐ No ☐ Yes
4. Do you have an accident investigation program? ☐ No ☐ Yes
   If yes, do you have a formal written accident report? ☐ No ☐ Yes
5. Do you have an early return to work program? ☐ No ☐ Yes
   If yes, is it? ☐ Formal ☐ Informal
   If yes, does it include salary continuation? ☐ No ☐ Yes
   If yes, does it include modified/light duty? ☐ No ☐ Yes
6. Do you test for drugs ☐ No ☐ Yes
   If yes, when? ☐ Pre-Hire ☐ Post Accident ☐ Random ☐ Near Miss

Safety Program Contd.

7. Are MVR's checked? ☐ No ☐ Yes
   If yes, how often _____
8. Are owners active in daily operations? ☐ No ☐ Yes
   If yes, are they excluded from coverage? ☐ No ☐ Yes
9. Are safety meetings conducted? ☐ No ☐ Yes
   If yes, how often do they occur? _____
   If yes, are they ☐ Formal / documented ☐ Informal
10. CPR training provided? ☐ No ☐ Yes If yes, number of employees certified _____
11. Any material handling exposures? ☐ No ☐ Yes
    If yes, Please explain____
    How much is lifted by hand ☐ <25 lbs. ☐ 25-40 ☐ 40+
    List any mechanical lifting devices used: ____
    Forklifts used? ☐ No ☐ Yes
    If forklifts used, is forklift training provided? ☐ No ☐ Yes
    Annual Certification for forklift drivers? ☐ No ☐ Yes
    Number of Forklift Drivers _____ Number of forklifts _____
12. Loss control services been performed in the last year? ☐ No ☐ Yes
    Has Cal/OSHA visited or cited your business in the last year? ☐ No ☐ Yes
    If yes to either of the above, please provide an explanation (on separate page if needed) _________________
    ____

13. Is PPE mandatory? ☐ No ☐ Yes
    Is there a progressive disciplinary program in place if employees fail to use the equipment?
    ☐ No ☐ Yes
    Personal protection equipment (PPE) provided? ☐ No ☐ Yes ☐ N/A
    What PPE is used? ☐ Back Belts ☐ Goggles ☐ Masks
    ☐ Face Guard ☐ Gloves ☐ Respirators
    ☐ Hearing protection devices
    ☐ Other (please describe): ____________________

14. Does the insured use any of the following? ☐ Ladder ☐ Scaffolding ☐ Scissor lifts ☐ N/A
    If scaffolding is used, does the insured build their own? ☐ No ☐ Yes
    Strict enforcement of utilization? ☐ No ☐ Yes ☐ N/A
    What is the maximum height at which you will work? _______________

15. The building / premises are? ☐ Owned or ☐ Leased
    Condition of premises? ☐ Excellent ☐ Very good ☐ Average

16. Please answer the following questions by marking the applicable box:
    Do you hold supervisors accountable for safety? ☐ No ☐ Yes
    Do you have a Hearing Conservation Program? ☐ No ☐ Yes
    Do you have a Hazard Communication Program? ☐ No ☐ Yes
    Is there a set procedure for reporting claims? ☐ No ☐ Yes
    Do you have a Blood Borne Pathogen Program? ☐ No ☐ Yes
    Documented physical inspection of the premises? ☐ No ☐ Yes
    Respiratory Program in place? ☐ No ☐ Yes ☐ N/A
    Is all machinery/equipment properly guarded? ☐ No ☐ Yes ☐ N/A
    Are all equipment operators trained/ certified? ☐ No ☐ Yes ☐ N/A
    Condition of equipment? ☐ New ☐ Good ☐ Average ☐ N/A
    Material Safety Data Sheets available for all chemicals and products used? ☐ No ☐ Yes ☐ N/A
    Written Lockout/Tagout/Blockout Procedures in place? ☐ No ☐ Yes ☐ N/A

Benefits

1. Group medical provided? ☐ No ☐ Yes
   If yes, name of healthcare provider ______________________________
   Percentage of employees enrolled _____%
   Percentage paid by employer _____%
   If group medical is provided, who is eligible ☐ FT ☐ PT ☐ Seasonal ☐ Management/Supervisors only?
2. Paid Sick Leave? ☐ No ☐ Yes Paid Vacation ? ☐ No ☐ Yes
3. What is the average weekly wage of the employees in the governing class? $_____
4. Retirement / Pension Plan? ☐ No ☐ Yes
   If yes above, Does employer contribute? ☐ No ☐ Yes
5. Do you use a specific medical provider to treat injured employees? ☐ No ☐ Yes

Hiring Practices

1. Are personnel files documented for pre-existing injuries? ☐ No ☐ Yes
2. Employee Orientation Program? ☐ No ☐ Yes
   If yes above, is the orientation? ☐ Verbal only ☐ Verbal and Documented
3. Please answer the following questions by marking the applicable box

Written Application used?	☐ No	☐ Yes	Is a background check service used?	☐ No	☐ Yes
Reference Checks?	☐ No	☐ Yes	Pre/Post employment Physicals?	☐ No	☐ Yes
Orthopedic back testing?	☐ No	☐ Yes	MVR's checked?	☐ No	☐ Yes
Pre-Employment drug testing?	☐ No	☐ Yes	Post accident drug testing?	☐ No	☐ Yes
Audio hearing tests?	☐ No	☐ Yes	Formal job descriptions on file?	☐ No	☐ Yes
Is job specific training provided?	☐ No	☐ Yes	Pathogenic testing done (i.e. lead)?	☐ No	☐ Yes

Driving Exposure

1. Are your employees engaged in any driving, pick-up, or delivery operations? ☐ No ☐ Yes
   If yes above, how frequently: ☐ Daily ☐ Weekly ☐ Other ______________________
   MVR checks performed? ☐ No ☐ Yes
   If yes, frequency ☐ Annual ☐ Semi-Annual
   Do you participate in the CHP Pull Program? ☐ No ☐ Yes
   Are motorcycles used for any driving pick-up or delivery operations? ☐ No ☐ Yes
   Average Travel Radius ☐ Less than 50 Miles ☐ 50 – 100 Miles ☐ Greater than 100 Miles
   How often do you do deliveries greater than 100 miles? ______________________
   # of Vehicles _____
   # of drivers _____
2. Vehicle/Fleet maintenance program? ☐ No ☐ Yes
   If yes, who performs the service? ☐ Outside Vendor
   ☐ In-house employees
3. Vehicle Inspection program? ☐ No ☐ Yes
4. Are company vehicles owned? ☐ No ☐ Yes If yes, are vehicles taken home? ☐ No ☐ Yes
5. Has a driver acceptability standard been established? ☐ No ☐ Yes
6. Do employees use company vehicles for personal business? ☐ No ☐ Yes
   Do employees use personal vehicles for errands or deliveries? ☐ No ☐ Yes
7. Is a PUC/DMV filing program required? ☐ PUC ☐ DMV ☐N/A
   If a PUC/DMV filing is required what is the motor carrier number? ______________________
   What is the exact name that appears on the PUC/DMV filing? ______________________

Traveling Exposure

1. Any out of state, international or overnight (within state) travel? ☐ No ☐ Yes
   If yes, please provide details ______________________
   What is the purpose? ______________________
   Who will travel? ______________________
   Mode of transportation? ______________________
   # of employees who travel? _____ Frequency? ______________________
   Duration? ______________________ Where? ______________________

Catastrophic Exposure

1. Does the insured work within 2 miles of the following: government or military bases, financial institutions, sports stadiums, arenas, theme parks, major bridges, tunnels, dams, utilities/power plants, transportation hubs, railroads, airports, shipping, historic / symbolic buildings, monuments or parks? ☐ No ☐ Yes

   If yes, please explain____

2. Do they have employees in a 4 story building or greater? ☐ No ☐ Yes

   If yes above, structure of buildings is: (tilt up concrete; masonry; steel; wood frame/stucco) ____________________

Claims

Please forward at least 4 years of loss information valued within 90 days of policy inception.

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 reoccurrences?
How did it occur? What was the injury?

Please include a copy of the most current experience modification worksheet available along with a copy of the Bureau Inspection Report

Additional Information/Comments:

______

______

______

Signed ______________________________ **Dated** ____________________

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Class Specific Questions

Healthcare (Convalescent Homes, Residential Care, Skilled Nursing)

1. Please provide the information on the type of service you provide:
    - _____% Skilled Nursing Care
    - _____% Intermediate Care
    - _____% Sub-Acute/Rehabilitation Care
    - _____% Assisted Living
    - _____% Residential Care
    - _____% Independent Living Services
2. Does the insured use a Hoyer Lift? ☐ Yes ☐ No
3. Does the insured adhere to a Dual Lift process? (2 staff members lifting a patient) Must be written into their procedures. ☐ Yes ☐ No
4. What % of the patients/residents are Ambulatory _____% or Non-Ambulatory _____%
5. What is the ratio between patients/residents and employees? _____
6. Is maintenance/landscape work sub-contracted? ☐ Yes ☐ No
7. What is the % of:
    - Private Pay Residents_____%
    - Medical/Medicaid Residents_____%
    - Medicare Residents_____%.
8. Does the insured require non-skid shoes? ☐ Yes ☐ No
9. Does the insured provide Transportation for the residents? ☐ Yes ☐ No
    - If Yes, # of vehicles _____ # of drivers _____
    - Radius driven in miles? 0-50 ☐51-100 ☐100+
    - How often? ☐ Daily ☐ Weekly ☐ Monthly