



**WORKERS' COMPENSATION**  
*Dedicated to Safety and Service*



**HEALTHCARE SUPPLEMENTAL APPLICATION**

**NAME OF APPLICANT:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**CITY / STATE / ZIP:** \_\_\_\_\_

**GENERAL EXPOSURE INFORMATION**

Description of Operations: \_\_\_\_\_

Number of years in business under the above name / operation: \_\_\_\_\_

Prior Workers Compensation Coverage:  Yes  No

Name of Current Carrier \_\_\_\_\_

If none, provide the owner(s) experience in managing or operating this type of business:

\_\_\_\_\_

Any other entities owned by this applicant?  Yes  No (if yes, please explain)

\_\_\_\_\_

What percentage of work is performed in the following categories? **(must equal 100%)**

Assisted Living Center \_\_\_\_\_

Home Health Care \_\_\_\_\_

Home Infusion \_\_\_\_\_

Homemaker Services \_\_\_\_\_

Hospice \_\_\_\_\_

Other (describe) \_\_\_\_\_

Hospital Services (inpatient) \_\_\_\_\_

Hospital Services (outpatient) \_\_\_\_\_

Pharmacy Services \_\_\_\_\_

Physical Therapy \_\_\_\_\_

Staffing Services (temp/perm) \_\_\_\_\_

Based on the above work exposures, what is the break down of employees under Direct Payroll (W-2 filed) and/or Subcontracted (1099 or other) according to the following jobs performed? (include full / part time totals)

	Number Employed	Number Contracted	Hospital Percent	Nursing Home	Client's Home
<b>Aides</b>					
LPN's					
RN's					
Nurse Practitioner					
Other (specify)					

Does the insured utilize contracted / subcontracted staffing for any services?  Yes  No  
(if yes, please answer sections below)

- a. Percentage of annual exposure (based on cost of labor / material) \_\_\_\_\_
- b. Type of work contracted on normal basis \_\_\_\_\_
- c. Are Certificates of Insurance maintained for the Workers Comp coverage?  Yes  No  
(if no, payroll for this exposure will be picked up at audit)

Does applicant have a formal safety program incorporated in operations?  Yes  No

Does applicant incorporate any of the following?

Periodic Safety Meeting(s), documented? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>
Written Safety Inspection Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>
Formal Lift Protection Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>
Formal Fall Protection Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>
Pre Hire Drug Testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>
Post Accident Drug Testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>
Second Injury Questionnaire Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>

If No to above, is applicant willing to implement safeguards into program?  Yes  No

Are all visits to patients' homes documented by employees accurately with report logs?  Yes  No

If Yes, how often are reports submitted to management? \_\_\_\_\_

What specific types of training do employees receive? \_\_\_\_\_

Is updated training provided on a regular basis?  Yes  No

If so, please advise how often. \_\_\_\_\_

What types of vehicles are used in the insured's operation?

Make: \_\_\_\_\_ Model: \_\_\_\_\_ How many? \_\_\_\_\_

How often serviced? \_\_\_\_\_ By whom? \_\_\_\_\_ Travel logs maintained?  Yes  No

MVR checks?  Yes  No Reviewed on a regular basis  Yes  No How often? \_\_\_\_\_

What is the company policy for maximum allowable moving vehicle accidents?

\_\_\_\_\_ Are these company vehicles or employees' personal auto? \_\_\_\_\_

What is the mile radius of operation? \_\_\_\_\_ How often traveled? \_\_\_\_\_

Are travel logs maintained?  Yes  No

Are background checks performed on prospective new professional hires?  Yes  No

New non-professional hires?  Yes  No

What is the maximum allowable ratio between ambulatory / non-ambulatory patients?

\_\_\_\_\_

Please advise of any specific accreditation(s) held by the company and / or professional employees.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_  
**(must be completed by an owner, officer or authorized representative)**

Name & Title : \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Agent: \_\_\_\_\_

Date: \_\_\_\_\_