

Insured: _____ **Effective Date:** _____

DBA: _____

Billing Plan Preference: Stipulated Installments Monthly payroll reporting (availability varies by carrier premium requirements)

Section 1: No Prior Insurance and New Ventures

- Reason for no prior insurance - select one answer:
 - Commencing to do business for the first time.
 - Operating with employees without WC coverage.
 - Operating without employees and now hiring for the first time.
 - Other: _____
- Date employees began working or will begin working for applicant: _____
- Years of industry experience: _____

Section 2: Payroll and Premium History

(All policies held within the last 4 years)

	Expiring Year	1 st Prior Year	2 nd Prior Year	3 rd Prior Year
Payroll				
Premium				

Section 3: Bankruptcy

- Business or any principal of the business declared bankruptcy in the last seven years: Yes No
 If Yes, please provide:
 Name of Principal: _____ Chapter of Bankruptcy: _____
 Date Filed: _____ Case Number: _____ Status: _____
 Court Where Case Was Filed: _____

Section 4: Licenses

- Contractors State License Board**
 CSLB Number: _____ OR CSLB App Number: _____
- Farm Labor Contractor License**
 Farm Labor Contractor? Yes No If yes, please provide Farm Labor Contractor License Number: _____
- Transportation Licenses - complete sections 10 & 11**
 USDOT Number: _____ DMV/MCP Number: _____
 PUC Number: _____ Permit Type: _____
- Other License Information**
 Other License Information: _____

Section 5: Additional General Questions

- Offer the majority of your eligible employees Health Insurance: Yes No
 If no, who is eligible: _____
 If yes, Health Insurance Carrier: _____
 Group Health: Yes No % paid by employer: _____ % of participation: _____
- Obtain workers from a professional employer organization (PEO), employee leasing firm, labor contractor, or any third-party entity: Yes No

- 3. Obtain temporary workers from other employers: Yes No
- 4. Assign temporary laborers to your current or potential clients: Yes No
- 5. Assign leased or long-term workers to your current or potential clients: Yes No

Section 6: Additional Questions

- 1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press): Yes No
- 2. Employ any relatives: Yes No
- 3. Employ any minors (under age 18): Yes No
- 4. Make any cash payments to employees or subcontractors: Yes No
- 5. Provide meals or lodging in lieu of wages: Yes No
- 6. Pay any employees by the piece: Yes No
- 7. Have any work at a maritime or offshore facility: Yes No
- 8. Have any locations/operations for which coverage is not required: Yes No
- 9. Have any operations outside of California: Yes No
- 10. Perform any asbestos removal: Yes No
- 11. Member of any trade or business association: Yes No

Please explain any answers marked yes:

Section 7: Management Practices Questions

- 1. Paid Time Off (PTO), Vacation, and Sick Time Programs: Yes No
- 2. Employee Assistance Program: Yes No
- 3. Medical/Healthcare insurance for employees: Yes No
- 4. Dental Insurance for employees: Yes No
- 5. Vision Insurance for employees: Yes No
- 6. Supplementary Disability Insurance for employees: Yes No
- 7. Employee Retirement Plans / Pension Plan / 401K for employees: Yes No
- 8. Employee Profit Sharing Plans: Yes No
- 9. Employee Life Insurance (Group or Term): Yes No
- 10. Employee Turnover Rates: 0%-5% 5%-10% 10%-15% 15%-20% Greater than 20%
- 11. Check off the hiring practices implemented by the applicant:

<input type="checkbox"/> Written job description	<input type="checkbox"/> Employee Code of Conduct	<input type="checkbox"/> Periodic performance appraisals
<input type="checkbox"/> Employee orientation / job-specific employee training	<input type="checkbox"/> Harassment prevention protocols	<input type="checkbox"/> Exit interview
<input type="checkbox"/> Drug-free Workplace		
- 12. Check all of the following that have been implemented by the applicant:

<input type="checkbox"/> Injury and Illness Prevention Program (IIPP)	<input type="checkbox"/> Respiratory Protection Plan	<input type="checkbox"/> Hearing Loss Prevention Plan
<input type="checkbox"/> Outdoor Heat Control Plan	<input type="checkbox"/> Confined Spaces Plan	<input type="checkbox"/> Fall Protection Plan
<input type="checkbox"/> Ladder Safety Plan	<input type="checkbox"/> Driver Safety Plan	<input type="checkbox"/> Forklift Safety Plan
<input type="checkbox"/> Emergency Response Plan	<input type="checkbox"/> Disaster Recover Plan	
<input type="checkbox"/> Blood-borne Pathogens Safety Program	<input type="checkbox"/> Airborne Infections Disease Prevention Program (COVID-19, etc)	
- 13. Workers' Comp Practices – Check all of the following that have been implemented by the applicant:
 - Conducts Accident Investigations (following WC injury)
 - Assists with WC Carrier 3-point contact – following WC injury (Employee/Employer/Medical Provider)
 - Commitment to timely claim reporting (within 24 hours of WC injury)
 - Return to Work Program / Offers Modified Duty to Injured Workers
 - Directing Injured Workers to WC Carrier's Medical Provider Network (MPN)

- 14. Does the applicant conduct regular periodic safety meeting with employees? Yes No
- 15. Does the applicant track and document their safety efforts and safety training? Yes No
- 16. Does the applicant provide necessary safety (personal protective) equipment to employees and any necessary training for the equipment? Yes No
- 17. Does the applicant provide safety incentives for employees who achieve compliance with stated goals? Yes No
- 18. Does the applicant enforce disciplinary consequences for employees who violate safety procedures? Yes No

Section 8: Prior State Fund Policies

- 1. Has the business been insured by State Fund: Yes No
 If yes, please answer the following:
 Name of entity and/or individual that is or was insured with State Fund: _____
 Most recent policy number: _____
 Coverage Dates: From: _____ To: _____

Section 9: Purchase Acquisition

- 1. Was this operation all or part of an existing business that was purchased or acquired: Yes No
 If yes, please answer the following:
 Percentage of business acquired: _____ Date ownership changed: _____
 Prior business owner's name: _____
 Prior business address: _____
 Prior name of business: _____
 Is prior owner related to the new owner: Yes No If yes, list relationship: _____
 Have operations changed since business acquired: Yes No
 Percentage of employees kept from previous owner: _____
 Are those employees earning more than 50% of the payroll: Yes No
 Additional comments: _____

Section 10: Automobiles and Travel

Business operations include driving by employees for the following purpose(s):

- 1. Delivery: Yes No Frequency of delivery: Daily Weekly Other: _____
 Delivery Radius: <50 Miles 50-100 Miles 101-200 Miles >200 Miles Over-night trips
- 2. Travel to or between jobsites/facility locations: Yes No
 If yes, frequency: _____ Radius: _____
- 3. Group transportation of employees: Yes No If yes, indicate max # of employees per vehicle: _____
- 4. Sales/Service Calls: Yes No If yes, frequency: _____ Radius: _____
- 5. # of authorized drivers: _____ # of company vehicles: _____
 # of employee-owned vehicles used in business: _____
- 6. Frequency of MVR checks: _____ Participation in CHP Pull program: Yes No
- 7. Driver acceptability standards have been established: Yes No
- 8. Vehicles inspection / maintenance program: Yes No Frequency: _____
- 9. Vehicle maintenance is performed by employees: Yes No
- 10. Employees take company vehicles home at night: Yes No

Section 11: Industry Specific Questions

Apartment Owner or Operator

- Total # of Units: _____ Units Per Each Location: _____
- Total # of maintenance employees: _____ Typical duties: _____
- Swimming Pool: Yes No
 If Yes, does pool have: Fence Self-latching Gate Rules Posted Accessible Life-Safety Equipment

Do employees perform any of the following types of work?

At heights over 12 feet: Yes No If yes, explain: _____

Extermination or fumigation: Yes No If yes, explain: _____

Furnace cleaning: Yes No If yes, explain: _____

Any work subcontracted: Yes No If yes, complete "Sub-Contracted Work" Section of this app

Attorneys

What type of law: _____ Any criminal law: Yes No Any insurance law: Yes No

Contractors (Complete this section for any risk performing contracting, service/repair or installation work)

Annual Gross Receipts: _____

General description of work done: _____

Indicate % of work in each of the following operations: (each line must equal 100%)

New Construction: Residential: _____ Commercial: _____ Industrial: _____

Remodeling: Residential: _____ Commercial: _____ Industrial: _____

Service/Repair: Residential: _____ Commercial: _____ Industrial: _____

Installation: Residential: _____ Commercial: _____ Industrial: _____

Interior work: _____ Exterior work: _____ Max height of work: _____

Equipment Used: Cranes/Booms Heavy Equipment Excavation Equipment Scaffolds Ladders Other

If any of the above used, describe: _____

Any work subcontracted: Yes No If yes, complete "Sub-Contracted Work" Section of this app

Sub-Contracted Work

List each operation sub-contracted to others: _____

Annual Subcontracted Cost (labor & materials): _____

The following items are maintained and kept current for all sub-contractors:

Certificate of workers' compensation insurance: Yes No

Certificate of general liability insurance with like limits and additional insured status: Yes No

Copy of each sub-contractor's license number: Yes No

List below current sub-contractors, including contractor's license numbers: (If more than 3 provide a separate list)

	Sub-Contractor 1	Sub-Contractor 2	Sub-Contractor 3
Name			
License #			

Landscaping or Lawn Service

Annual Gross Receipts: _____

Any use of pesticides/herbicides: Yes No

If yes, explain: _____

Tree Trimming: Yes No If yes, % of total operations: _____ Work performed: from heights from ground

If tree trimming work from heights, describe: _____

Work along highways or freeways (including on/off ramps) or conducting traffic diversion: Yes No

If yes, explain: _____

Trenching operations and/or work below depth of 4 feet: Yes No

If yes, explain: _____

Hotel/Motel

Annual Gross Receipts: _____

Food service: Operate own: Yes No Subcontract: Restaurant Bar Both

Gross Receipts: Food: _____ Alcohol: _____

Entertainment: Yes No Lounge Armed Security

Operations: Year Round Seasonal Conference Center

Shuttle service: Yes No How many vans: _____

How are maids compensated: Salary Hourly Wage Flat Rate Per Room

Who flips the mattresses and how are they turned: _____

Restaurants/Bars

Annual Gross Receipts: _____ Alcohol Receipts (% of gross receipts): _____
Average Entrée Price: _____
Catering: Yes No % of revenue: _____
Delivery: Yes No % of revenue: _____ If yes, radius of delivery area: _____
Hours of operation: _____ to _____ Number of Daily Shifts: _____
Number of: Hosts _____ Wait-staff _____ Cooks _____
Bartenders _____ Valet Parkers _____ Security _____
Entertainment: Yes No If yes, describe: _____
Dance floor: Yes No Square Ft: _____
Food truck: Yes No

Manufacturing

Annual Gross Receipts: _____
Product Description: _____
Hours of operation: _____ to _____ Number of Daily Shifts: _____
Lock-out/Tag-out program in place: Yes No
Machine guarding: Yes No
Point of operation: Yes No Drive mechanism: Yes No Moving parts: Yes No
Type of Machines Used: _____
Material handling exposure: Yes No Lifting: Below 50 lbs. Above 50 lbs. _____
Off premises operations: Yes No Percentage: _____ Where / What: _____

Retail/Wholesale

Annual Gross Receipts: _____ Wholesale: _____ Retail: _____
Type of merchandise: _____ Import Domestic
Hours of operation: _____ to _____ Number of Daily Shifts: _____
Employee Compensation: Flat Salary Hourly Wages Commission
Outside sales employees: Yes No Lifting exposure or repackaging: Yes No Lbs.: _____
Is there assembly: Yes No Installation of product at customer premises: Yes No

Service Stations/Auto Repair Shops/Transmission Shops

Annual Gross Receipts: _____ Hours of operation: _____ to _____
Gas operation: Full Service Self Service
Repair Operation: Yes No Tire Repair/Installation Over 1-Ton Truck
Towing: Yes No Contract tow: Yes No
Mini-Market: Yes No Alcohol sold: Yes No
Bullet proof cashier booth: Yes No Drop safe or registers: Yes No
Car Wash: Yes No If yes: Self Serve Full Serve
Access to freeway: 0-1 mile 1-2 mile 2+ mile

Signature

To be completed by broker, owner, or an officer/partner of the business of the business seeking coverage

Insurance Code Article 6, Sec.11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. All insurance carriers reserve the right to verify the accuracy of information provided to them by insurance applicants. I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Completed by: _____ Title: _____

Signature: _____ Date: _____