

Supplemental Application – Workers’ Compensation

Name of Applicant: _____ Company Website: _____
 Effective Date: _____ Expiration Date: _____
 Any change to the Normal Anniversary Date? _____ FEIN (please include all): _____
 Has the applicant had any OSHA citations in the last five years? yes no
 Has the applicant had any EPA citations in the last five years? yes no
 Has the applicant had any occupational disease (OD) claims in the last five years? yes no
 Is the applicant a member of ISRI? yes no
 Is the applicant CAR Designated? yes no
 Is the applicant RIOS Designated? yes no

Policy Year	Premium & Carrier	Payroll by State and Class Code
Expiring Year		
1 st Prior Year		
2 nd Prior Year		
3 rd Prior Year		
4 th Prior Year		

Total FT EE: _____ Total PT EE: _____ Total Full Time Equivalents: _____ Hours of operation: _____
 Number of authorized drivers: _____ Number of vehicles: _____
 Number of W2 forms issued last year: _____ Average hourly wage in governing class: \$ _____
 Is group (3+) transportation provided? yes no Are there greater than 50 employees in any one location? yes no
 If so, identify each location and provide total head count and payroll per location.
 Do any employees work from home? yes no
 Does the applicant have any foreign Workers’ Compensation exposure? yes no
 If yes, please provide head count and number of days visited by country: _____

Financial:

For the most recent fiscal year-ended, please provide the following:
 Net income: _____ Gross Revenue: _____
 Total Assets: _____ Gross Revenue - Prior Year: _____
 Total Equity: _____ Gross Revenue – Forecasted Current FY : _____
 Has the applicant at any time files for Chapter 7 or Chapter 11 bankruptcy? (if so, please provide details) yes no

Premises:

Are interconnected smoke detectors in place? yes no Is the building sprinklered? yes no
 Are fire extinguishers present? yes no Are there multiple means of egress? yes no
 Do security cameras record daily operations? yes no Is there a fire/emergency evacuation plan in place? yes no
 Are emergency eyewash stations present? yes no Are security cameras in use in work areas? yes no
 Is emergency lighting in place? yes no Is there adequate ventilation in work areas? yes no
 Years at current location: _____ Age of building occupied: _____
 Building is owned leased Equipment condition: New Good Other _____
 Number of stories: _____ Number of Occupied Buildings: _____

Benefits:

Are all employees eligible? yes no If not, who is eligible?: _____
 Is group health insurance provided? yes no Percentage of total employees participating: _____
 Name of healthcare provider: _____ Percentage paid by employer: _____
 Is disability insurance provided? yes no Is sick paid leave provided? yes no
 Is paid vacation provided? yes no Is a retirement/pension plan provided? yes no

Hiring practices:

Are written applications used? yes no Do any employees work from home? yes no
 Are reference checks performed? yes no Are criminal background checks performed? yes no
 Is MVR screening criteria in place? yes no Are personnel files documented for pre-existing injuries? yes no

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Are motor vehicle record checks performed? yes no
 Is any leased, volunteer, or temporary labor used? yes no
 Is drug testing part of the hiring process? yes no
 Is a drug/substance abuse program available? yes no
 Is the labor force unionized? yes no
 Number of employees under the age of 18 or over 60:
 Full Time: Part Time:

Is there a new hire orientation program? yes no
 Does orientation include a review of safety / Workers’ Comp? yes no
 Is orthopedic back screening provided? yes no
 Is physician screening provided? yes no
 Is any day labor or temp staffing used? yes no
 What is the employee : supervisor ratio?:

Risk Management:

Is there a safety incentive program in place? yes no
 Is RTW modified duty provided to all EE? yes no
 Is a written safety program in place? yes no
 Does the insured have a full time risk manager on staff? yes no
 Are safety meetings or training provided? yes no
 Is post-accident drug / substance abuse testing practiced? yes no
 Are subcontractors/independent contractors used? yes no
 Does employer agree to participate in the Carrier’s medical provider network? yes no

Is a light duty return to work (RTW) program in place? yes no
 Does RTW includes full wages? yes no
 Are owners active in daily operations? yes no
 Is an IIPP in place and enforced? yes no
 Are all workplace injuries investigated by a safety committee? yes no
 Is all machinery guarded in compliance w/ OSHA standards? yes no
 If so are certificates of Work Comp insurance obtained? yes no

Operations:

Are personal vehicles used for company business? yes no
 Are any company vehicles taken home at night? yes no
 Is there any out of state travel? yes no
 Is any work done off-site? yes no If so, please describe the activities along with the frequency of the work and what tools/equipment may be used.

How often is your equipment inspected?
 Who inspects the equipment and what qualifications does this person have?

If your operation includes the collection of roll off containers please describe this operation and the associated safety controls in place. Please include mention of loading/unloading and tie down:

Does your operation perform torch cutting or welding? yes no If so, please describe your safety protocols for this practice. Also note the safety controls in place for open flame cutting or welding near flammable materials:

Does your facility actively screen for the following materials?

- | | | |
|---|---|---|
| <input type="checkbox"/> Anything containing PCB’s (light ballasts, capacitors, transformers etc) | <input type="checkbox"/> Potentially radioactive material | <input type="checkbox"/> Airbags (sodium azide) |
| <input type="checkbox"/> Anything containing CFC’s | <input type="checkbox"/> Heavy metals | <input type="checkbox"/> Asbestos |
| | <input type="checkbox"/> Precious metals | |

Safety Training:

Has the applicant signed the ISRI Safety Pledge? yes no
 Are training programs in place for new and existing employees? yes no If yes, list all that apply:

<input type="checkbox"/> New Hire Orientation/ Safety Training	<input type="checkbox"/> Mobile Equipment Safety
<input type="checkbox"/> Hazard Communication Training	<input type="checkbox"/> Forklift & heavy machinery operators are certified
<input type="checkbox"/> Lock-Out /Tag-Out Training	<input type="checkbox"/> Emergency Evacuation
<input type="checkbox"/> Hazardous Substance Handling	<input type="checkbox"/> Driver Safety Training
<input type="checkbox"/> OSHA Blood borne pathogens safety (auto dismantlers)	<input type="checkbox"/> Prompt compliance with loss control recommendations
<input type="checkbox"/> Proper Use of Personal Protective Equipment	<input type="checkbox"/> Other:
<input type="checkbox"/> Strain Prevention / Proper Lifting Procedures	

Frequency of Training:

PPE Provided and or required:

AmeriComp Recycling

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- | | | |
|---|---|---|
| <input type="checkbox"/> Steel toe boots | <input type="checkbox"/> Hardhat | <input type="checkbox"/> Safety belt / Back brace |
| <input type="checkbox"/> Gloves | <input type="checkbox"/> Welder's apron | <input type="checkbox"/> Respiratory equipment |
| <input type="checkbox"/> Protective eyewear | <input type="checkbox"/> Welder's shield & helmet | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Hearing protection | <input type="checkbox"/> Lifting straps | |

Ergonomics program:

Is ergonomically flexible furniture used? yes no

Are employees who perform repetitive motion duties rotated to different tasks throughout the course of the day? yes no

Is worksite analysis conducted to identify jobs and workstations that contribute to cumulative trauma problems? yes no

Are conveyors and sorting lines set at a such a height to as to avoid bending, stooping, straining? yes no

Large Loss History:

Has the insured had any losses greater than \$25,000 in the past five years? yes no

If yes, please provide details below.

Claimant Name:	Date of loss:
Position at time of loss:	<input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Litigated
Paid:	Indemnity: Medical: Expense:
Incurred:	Indemnity: Medical: Expense:
Did the insured make any changes in operations as a result of this loss? <input type="checkbox"/> yes <input type="checkbox"/> no	
Please explain:	

Prepared by: _____ Title: _____ Date: _____

Signature: _____