Americomp
Supplemental WC Questionnaire
Healthcare – other than Social Services

AMWINS™
PROGRAM UNDERWRITERS

Please type or print clearly in ink. All sections must be completed fully. If you need more space, attach additional sheets as needed, using company letterhead. If you have been in operation for less than 3 years, please attach the resumes of the owners and/or managers.. "You", "your", "applicant", and "company" all refer to the proposed named insured(s).

Insured Entity (Legal) Name: _____

Proposed Effective Date of Coverage: _____

Federal Employee ID Number(s): _____
(If more than one entity/subsidiary, please attach description and % owned for each

GENERAL INFORMATION:

Is the applicant currently insured? ☐ Yes ☐ No

If so, are they currently insured in the Assigned Risk Pool? ☐ Yes ☐ No

Is the applicant a PEO, Employee Leasing Company, Temporary Staffing Agency, Labor Contractor, or otherwise supply employees to another employer on a contract, temporary or on call basis? ☐ Yes ☐ No

If "yes", please provide details. _____

What month and year did this business start? _____

How many years / months of direct health care related experience do the owners/proprietors have? _____

Have your operations ever been suspended by and local, state, or federal regulatory authority? ☐ Yes ☐ No

If yes, why? _____

Does the applicant have general liability & professional liability insurance in force? ☐ Yes ☐ No

If yes, Carrier?: _____ Effective Date?: _____

Indicate employee annual turnover rate_____%

Workforce Details:

- Avg. Hourly Wage: RN $___.___ LPN/LVN $___.___ PT/OT $___.___ CNA $___.___ HHA $___.___ NP $___.___
  MD $___.___ Dentist $___.___ Admin $_ .___ Other $___.___ (describe)_____
- Total Employees #:_____ # of Full time Equivalents:_____
- # of Full Time Professional Employees (NP, RN, LPN, CPT, CNA): _____
- # of Full Time Non-Professional Care Providers: _____
- # of Part Time Professional Employees (NP, RN, LPN, CPT, CNA): _____
- # of Part Time Non-Professional Care Providers: _____
- # of Administrative Support/Clerical Employees: _____
- Average # of patients visited per day by each employee: _____
- # of Volunteers Annually?_____ or ☐ No Voluntary or Donated Labor
- Total Number of volunteer work hours annually?*_____
  **# of volunteers x number of days x 8hr per day, round to the nearest hour.*

Please indicate where your employees perform their work:

☐ Private Homes _____% ☐ Clinics _____% ☐ Nursing Homes _____%
☐ Doctor's Offices _____% ☐ Hospitals _____% ☐ Corporate Offices _____%
☐ Clinic Setting _____% ☐ *Other Locations____% ☐ *Community Residences_____%
☐ *Correctional Facilities (Penal Institutions –youth or adult, detention centers, 'boot' camps, etc.)_____%
*Please describe: _____

Do you have any **24 hour** employee exposures such as live-in-home employees, etc.? ☐ Yes ☐ No

If "yes", please provide details. _____

Please enclose any available informational brochures describing operations, locations, services, etc. ☐ See Attached.

What percentage of your revenue is derived from the following sources:_____% Private Pay_____% Government Reimbursement

Website Address: www. _____

What percentage of your payroll is for: ☐ No exposures in the below classes.

- Youth or Residential housing risks_____% COED residential housing risks _____%

o Mentally handicapped _____% Alzheimer's patients _____%

ACCREDITATION: Is your operation accredited / certified by any of the following governing bodies?

- ☐ Medicare
- ☐ Medicaid
- ☐ The Joint Commission (JC)
- ☐ Accreditation Commission for Health Care (ACHC)
- ☐ Community Health Accreditation Program (CHAP)
- ☐ None
- ☐ Other: _____

HIRING PRACTICES / EMPLOYEE SCREENING - Check all that apply to your operations:

- ☐ Written Applications Required
- ☐ Criminal Background Checks
- ☐ New Hire Physician Screening
- ☐ On the Job Skill Testing
- ☐ Documented Job Descriptions
- ☐ Driving Records are Checked
- ☐ Orthopedic Back Screening
- ☐ Reference Checks are Required
- ☐ Pre-existing Injuries are Noted in HR Files
- ☐ License / Certifications are Verified

BUSINESS OPERATIONS - Check all that apply to your operations:

- ☐ Home Health Care Provider
- ☐ Hospice Provider
- ☐ Retail Pharmacy
- ☐ Rest Home / Senior Living
- ☐ Mental Health Counseling
- ☐ Drug treatment/Detox
- ☐ Halfway House
- ☐ Correctional Facility Nursing
- ☐ Visiting Nurse Agency
- ☐ Nurse Registry
- ☐ Closed Pharmacy
- ☐ Assisted Living
- ☐ Crisis Response Team
- ☐ Inpatient Psychiatric Treatment
- ☐ Onsite Pharmacy
- ☐ Correctional Facility Counseling
- ☐ Supplemental Medical Staffing
- ☐ Medical Equipment Supplier
- ☐ Infusion Therapy Provider
- ☐ Physical Therapy / Occupational Health
- ☐ Substance Abuse Counseling
- ☐ Crisis Hotline
- ☐ Crisis "Shelters"
- ☐ Behavioral Problem Youth Counseling
- ☐ Other _____

HISTORICAL PAYROLL & PREMIUM INFORMATION:

Policy Year	Payrolls by Class Code / State	Expiring Premium / Carrier
Current		
1st Prior		
2nd Prior		
3rd Prior		
4th Prior		
5th Prior		

DRUG FREE POLICY:

a. Have you published a statement notifying all employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited and specified the actions that will be taken against employees for violations of the prohibition? ☐ Yes ☐ No

b. Do you required that each employee be given a copy of the drug free policy and as a condition of employment the employee must agrees to abide by the terms of the statement. ☐ Yes ☐ No

c. Do you require both pre-employment / and random post-employment drug testing? ☐ Yes ☐ No

OSHA VIOLATION HISTORY:

Has the applicant been cited for any OSHA violations in the past 3 years? ☐ Yes ☐ No If yes, violation dates and citation details: _____

_____

SAFETY PROGRAM(S) - Check all that apply to your operations:

- ☐ Formal Accident/Injury Investigations*
- ☐ Labor/Management Safety Committee
- ☐ Mentoring process for new employees*
- ☐ Personnel Evaluations include "safety"
- ☐ Return to Work/Modified Duty
- ☐ Functional testing of new hires
- ☐ Prompt compliance with Loss Control recommendations
- ☐ Safety Incentive Program
- ☐ New Employee Orientation*
- ☐ Driver Training/Travel Logs
- ☐ Blood Borne Pathogens
- ☐ Management Involvement in Safety (describe)

*Describe: _____

_____

PATIENT HANDLING: What percentage of your patients / clients fall into each of the following categories?

_____% **Total Dependence** – Cannot help at all with transfers. Requires total transfer at all times.

_____% **Extensive Assistance –** Can perform part of activity, usually can follow simple directions may require tactile cueing, can bear some weight, sit up with assistance, has some upper body strength, may be able to pivot transfer.

_____% **Limited Assistance –** Highly involved in activity, able to pivot transfer and has considerable upper body strength and bears some weight on legs. Can sit up well, but may need some assistance. Guided maneuvering of limbs or other non-weight bearing assistance three or more times; help provided one or two times during the last seven days.

_____% **Supervision –** Oversight, encouragement, or cueing provided three or more times during the last seven days or physical assistance provided only one or two times during the last seven days.

_____% **Independent –** Can ambulate normally without assistance, in unusual situations may need some limited assistance.

LIFTING SAFETY- Check all that apply to your operations:

☐ Patient Handling/Transfer Training	☐ Proper Lifting Technique Training
☐ Gait Belts are provided & used	☐ Transfer Belts are provided & used
☐ Patient Lifts are provided & used	☐ Team Lifts
☐ Patient Assessments are conducted prior to lift	☐ Lifting plan is communicated to patient prior to lift
☐ Patients use electric / power beds	☐ Shower Carts / Gurneys
☐ Maximum lift weight limitations	☐ Patient Bed Height Requirements (to avoid awkward lifts)
☐ Proper non-slip footwear is required	☐ All lifting injuries are investigated for root cause

☐ Other Lifting Equipment used: _____

DRIVER SAFETY: (if any EE's drive any vehicle during their shift, your operation has a WC driving exposure)

a.	Do you have a written driver safety program?	☐ Yes	☐ No
b.	Is a disciplinary policy in place for violating the driver safety program?	☐ Yes	☐ No
c.	Do your employees run errands or transport patients/clients?	☐ Yes	■ No
d.	Pre-Employment Motor Vehicle Report (MVR) review?	☐ Yes	☐ No
e.	Written Standards for what is acceptable on the Motor Vehicle Report (MVR)?	☐ Yes	☐ No
f.	What is the frequency of MVR review?	_____	
g.	Radius of operation: Average:_____	Max:_____	
h.	Do you require your employees to provide evidence of personal auto insurance	☐ Yes	☐ No
i.	Do you require that they carry Uninsured/ Underinsured Motorist Coverage?	☐ Yes	☐ No
j.	Do you require all employees to wear a seatbelt while driving during their shift?	☐ Yes	☐ No
k.	Do you require employees to refrain from texting while driving during their shift?	☐ Yes	☐ No

BENEFITS:

Do you provide your employees with (check all that apply):

☐ Health Insurance ☐ Dental Insurance ☐ Short Term Disability ☐ Long Term Disability ☐ Paid Vacation

If no, or if declined, do you verify that employees have health insurance in place? ☐ Yes ☐ No

Comments: _____

CARE & CONDITION OF PREMISES:

a. Do your employees perform the following task yourself or hire a subcontractor:
   - Housekeeping/Facilities Maintenance: ☐ Employees ☐ Subcontractor hired
   - Snow / Debris Removal : ☐ Employees ☐ Subcontractor hired

b. Age & Condition of equipment: _____ ☐ N/A

c. Equipment safety guarded: _____ ☐ N/A

d. Do you use checklists for all that apply above? ☐ Yes ☐ No

e. Do you obtain certificates of insurance from ALL hired contractors providing evidence of currently in force general liability and workers' compensation insurance coverage? ☐ Yes ☐ No ☐ N/A-no subs;

UNCONTROLLED WORK ENVIRONMENTS:

a. Do you pre-inspect client/patient homes for the safety of your staff? ☐ Yes ☐No ☐N/A;
If no, please describe the process if the environment is cited as being un-safe by an employee?

_____

b. How are safety inspections documented? _____
c. Are minimum safety standards / condition of premises formally documented? ☐ Yes ☐No
d. Are potential clients ever rejected based on safety standards / condition of premises ☐ Yes ☐No
e. Are inspection reports shared with/ communicated to staff prior to visits? ☐ Yes ☐No ☐N/A
f. Is a hazard communication policy in place for employees to report unsafe conditions? ☐ Yes ☐No

If your employees visit private residences, which statement best describes your policy regarding subrogation of claims arising directly from negligent maintenance hazards at your client's premises?

☐ We will hold the client responsible for the safety of their premises.
☐ We waive our rights to subrogation against our clients.

CLAIM MANAGEMENT:

Do you have a formal, written accident investigation procedure / policy ☐ Yes ☐ No
Has the insured had 3 or more "violent" WC claims in the past 5 years? ☐ Yes ☐ No _____
Do you take remedial action when a source of claims has been identified? ☐ Yes ☐ No

Do you provide an Employee Handbook with details for safe practices, claim reporting, drug free policy, accident investigation, etc.?
☐ Yes ☐ No

STATE UNEMPLOYMENT NUMBERS: Please provide your unemployment account numbers for the following states (if any):

AR: _____
HI: _____ - 10 Digit Alpha Numeric Dept. of Labor Number
ME: _____ - 10 Digit Numeric UAIN Number
MN: _____ - 10 Digit Numeric or "Exempt" State Unemployment Number
NJ: _____ - 12 Digit Numeric Taxpayer ID Number
NM: _____
NY: _____ - 7 Digit Alpha Numeric State Unemployment Number
RI: _____ - 10 Digit Numeric UAIN Number
VT: _____
CO: _____

_____ X _____
Applicant Name/Title (printed): Signature: Date:

_____ X _____
Agent Name/Title (printed): Signature: Date:

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FRAUD WARNINGS

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO CALIFORNIA APPLICANTS: In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: "It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: "Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

NOTICE TO HAWAII APPLICANTS: "For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both."

NOTICE TO KENTUCKY APPLICANTS: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

NOTICE TO LOUISIANNA APPLICANTS: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

NOTICE TO MAINE APPLICANTS: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits."

NOTICE TO NEW JERSEY APPLICANTS: “Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.”

NOTICE TO NEW MEXICO APPLICANTS: “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

NOTICE TO NEW YORK APPLICANTS: “Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.”

NOTICE TO OHIO APPLICANTS: “Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.”

NOTICE TO OKLAHOMA APPLICANTS: “WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: “Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.”

NOTICE TO TENNESSEE APPLICANTS: “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

NOTICE TO TEXAS APPLICANTS: In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO VIRGINIA APPLICANTS: “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.