eWC Supplemental Application

Insured: _____ Web Address: _____

Description of Operations:

Is the insured a Professional Employer Organization, Temporary Staffing Organization or Labor Contractor? ……Yes No

Are There Any Other Commonly Owned Businesses Which Are Separately Insured ..... Yes No

If Yes, Explain: _____

Are There Any States in Which the Insured Operates That Are Covered Elsewhere ..... Yes No

If Yes, Explain: _____

PRIOR PAYROLL AND PREMIUM INFORMATION

	Current Year	Prior Year	Prior Year	Prior Year	Prior Year
Premium					
Payroll					

HIRING PRACTICES AND BENEFITS

Written Applications Used .....Yes No

References Checked .....Yes No

Pre-Employment Physicals .....Yes No

MVR's Checked …….. Yes No Not Applicable

Volunteer Labor Used.....Yes No

Drug Screening (check those that apply):

Pre-Placement Random .....Post-Accident

Employee Turnover Rate ..... ….____%

Group Medical Benefits Provided .....Yes No

If Yes, % of Employees Covered .....____%

If work is subcontracted without certificates of insurance, is all payroll included in this submission? ….. Yes No Not Applicable

Is there any interchange of labor between the insured and any other entity which is not included in this submission? ……. Yes No

MANAGEMENT PRACTICES AND LOSS CONTROL

Number of years in business …….…… ___ Years

Owners/Officers Active In Operations .....Yes No

Any lapse in coverage in the past 24 months? ……. Yes No

Has the insured been cancelled or non-renewed due to misrepresentation or fraud within the past 3 years?.....Yes No

Formal Safety Program .....Yes No

Safety Committee .....Yes No

Light Duty / Early Return to Work Program.....Yes No

Employee Supervision .....Yes No

Maximum Weight Lifted Manually: ..... ____ lbs

FINANCIAL CONDITIONS

Has the insured filed for bankruptcy within the last three years? ……..Yes No

Has the insured been self-insured within the last three years? ……. Yes No

If Stop Gap Coverage Is Requested, Provide Annual Premiums Paid in ND, OH, WA, and WY.
If Foreign Travel Exposure Is Requested, Provide Countries Visited, Work Performed And Total Number Of Days Per Year.
If Coverage For Volunteer Labor Is Requested, Provide How Many, Duties, Total Annual Hours For All Volunteers.
If USL&H Is Requested, Provide Class Codes And Actual Exposures.

Signature:	Information Supplied By: Broker Insured	Date:

Health Care Questionnaire

Please provide details/explanation for any questions answered yes

Does applicant have shifts that are greater than 12 hours in length per 24 hour period? Yes ☐ No ☐

Does applicant have a lifting policy in place? please provide details of procedures Yes ☐ No ☐

Any Mechanical loading and unloading of patients (such as Hoyer Lifts)? Yes ☐ No ☐

Does applicant have a contact and disease policy in place? Yes ☐ No ☐

Does applicant Employee training program in place? Yes ☐ No ☐

Written blood pathogen program in place Yes ☐ No ☐

Use an volunteers workers if yes please provide details Yes ☐ No ☐

Are 50% or greater of the employee's RN's LVN's, CNA's or some other equivalent where there is patient care?
Yes ☐ No ☐

Does applicant have a mobile operation Yes ☐ No ☐

Any group transportation? please provide details including radius of operations Yes ☐ No ☐

Any exposure to Aids/HIV Yes ☐ No ☐

What percentages of patients are non-ambulatory? Yes ☐ No ☐

Do any locations have 50+ employees working at 1 time at the same location Yes ☐ No ☐

Need maximum number of employees at any one time at each location for employee concentration check.

Details on all losses >25,000: details on each loss - what caused loss and what changes, if any, made as a result to reduce likelihood of reoccurrence?

If a multistate risk, premium vs. losses break down per state.