

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	Employee Turnover Rate ..... %
References Checked ..... Yes No	Group Medical Benefits Provided ..... Yes No
Pre-Employment Physicals ..... Yes No	If Yes, % of Employees Covered ..... %
MVR's Checked ..... Yes No Not Applicable	If work is subcontracted without certificates of insurance, is all payroll included in this submission? ..... Yes No Not Applicable
Volunteer Labor Used ..... Yes No	Is there any interchange of labor between the insured and any other entity which is <u>not</u> included in this submission? ..... Yes No
Drug Screening (check those that apply):	
Pre-Placement          Random          .....Post-Accident	

**MANAGEMENT PRACTICES AND LOSS CONTROL**

Number of years in business ..... ___ Years	Formal Safety Program ..... Yes No
Owners/Officers Active In Operations ..... Yes No	Safety Committee ..... Yes No
Any lapse in coverage in the past 24 months? ..... Yes No	Light Duty / Early Return to Work Program..... Yes No
Has the insured been cancelled or non-renewed due to misrepresentation or fraud within the past 3 years?.....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.