



**HEALTHCARE SUPPLEMENTAL APPLICATION**



Company name: \_\_\_\_\_  
Insureds Federal Tax ID Number: \_\_\_\_\_  
Number of years in business: \_\_\_\_\_ years. If less than 4 years, number of years in the trade: \_\_\_\_\_  
Is the owner active in the business: Yes  No  Duties performed: \_\_\_\_\_

Describe operations of the insured: \_\_\_\_\_  
\_\_\_\_\_

**BENEFITS**

Does insured provide group medical insurance? Yes  No  Employer contribution: \_\_\_\_\_%  
What percentage of employees are covered by the plan? \_\_\_\_\_%  
Waiting period: 30 days  60 days  90 days  Other: \_\_\_\_\_  
Name of group medical provider: \_\_\_\_\_  
Who is eligible? All employees  Only full time  Other: \_\_\_\_\_  
Does insured provide life insurance? Yes  No  If yes, employer contribution: \_\_\_\_\_%  
Does insured provide disability insurance? Yes  No  If yes, employer contribution: \_\_\_\_\_%  
Paid vacation: Yes  No  Paid sick leave: Yes  No  401K profit sharing: Yes  No

**MANAGEMENT**

Does insured have a return to work program? Yes  No  With full pay? Yes  No   
Modified duty offered to injured employees? Yes  No   
Is the insured willing to implement safety recommendations made by the carrier? Yes  No   
Is the insured willing to implement loss control recommendations made by the carrier? Yes  No   
Additional Comments: \_\_\_\_\_  
\_\_\_\_\_

**OPERATIONS**

Hours of operation: \_\_\_\_\_ to \_\_\_\_\_ Number of days per week: \_\_\_\_\_ Number of shifts: \_\_\_\_\_  
Percentage of new construction: Residential \_\_\_\_\_% Commercial \_\_\_\_\_% Industrial \_\_\_\_\_%  
Percentage of remodeling: Residential \_\_\_\_\_% Commercial \_\_\_\_\_% Industrial \_\_\_\_\_%  
Percentage of repair work: Residential \_\_\_\_\_% Commercial \_\_\_\_\_% Industrial \_\_\_\_\_%  
Percentage of work subcontracted: \_\_\_\_\_% What kind of work is subcontracted? \_\_\_\_\_

Any work performed above two stories? Yes  No  If yes, describe: \_\_\_\_\_

Any excavation work performed? Yes  No  If yes, maximum depth: \_\_\_\_\_

Are deliveries made? Yes  No  Frequency: Daily  Weekly  Other

Delivery radius: Under 50 miles  50-100 miles  Over 100 miles

Vehicles owned: Yes  No  Are vehicles taken home? Yes  No

Vehicle maintenance program: Yes  No

Any changes in Operations in the last 5 years: yes  no  if yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**PREMISES**

Housekeeping / cleanliness at the jobsite: Excellent  Good  Poor   
Condition of equipment: Excellent  Good  Poor   
Proper safeguards? Yes  No   
Any jobsite security provided: Yes  No  If yes, describe: \_\_\_\_\_  
Additional comments: \_\_\_\_\_

**HIRING PRACTICES**

Complete written applications: Yes  No  Pathogenic test (i.e. lead): Yes  No   
Reference checks: Yes  No  Audio testing: Yes  No   
Pre/post employment physicals: Yes  No  Orthopedic back test: Yes  No   
Drug/substance abuse tests: Yes  No  MVR's checked: Yes  No   
How are potential new employees hired (check all that apply)?  
Referrals  Word of Mouth  Newspaper Ads   
Recruiters  Union Hall  Other  Describe: \_\_\_\_\_

**EMPLOYEES**

Number of employees: Full time: \_\_\_\_\_ Part time: \_\_\_\_\_ Seasonal: \_\_\_\_\_  
Employee turnover is: Low  Average  High   
What is the hourly wage of the governing class of employees: \$ \_\_\_\_\_ per hour.  
Do employees utilize any safety protection: Yes  No  Describe: \_\_\_\_\_  
\_\_\_\_\_  
Do employees travel out of state/country on business: Yes  No  If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

**SAFETY**

Person responsible for safety: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
Does insured use a specific medical provider to treat injured employees? Yes  No   
Clinic  Physician  Emergency Room  Other: \_\_\_\_\_  
Written safety program (SB198): Yes  No  Safety incentive program: Yes  No   
Full time safety director: Yes  No  Part time (less than 50%) Yes  No   
Safety / tailgate meetings conducted for all employees: Yes  No  How often: \_\_\_\_\_  
Safety training program in place for employees: Yes  No   
Equipment safeguards utilized: Yes  No  Describe: \_\_\_\_\_  
\_\_\_\_\_  
Equipment inspection / maintenance program: Yes  No  If yes, describe: \_\_\_\_\_  
\_\_\_\_\_

Slip & fall prevention program in place: Yes  No   
Hazardous materials communication program in place: Yes  No   
Lock out / tag out program in place: Yes  No  Confined space program in place: Yes  No   
Industrial truck / vehicle program in place: Yes  No  Violence intervention program: Yes  No   
Drug / alcohol awareness program: Yes  No  First aid kit kept at the jobsite: Yes  No   
Any employees trained in first aid: Yes  No  Any employees trained in CPR: Yes  No

**BROKER INFORMATION**

Does this broker currently control the workers' compensation? Yes  No  If yes, how many years \_\_\_\_  
Does this broker currently control any other lines of insurance for this insured? Yes  No





HEALTHCARE SUPPLEMENTAL APPLICATION



\*\*\*\*\*PLEASE PROVIDE THE FOLLOWING DETAILS OF LOSSES OVER \$50,000 \*\*\*\*\*

Claimant Name: \_\_\_\_\_ Date of Loss: \_\_\_\_\_
Job/Position at Time of Loss: \_\_\_\_\_ Open [ ] Closed [ ] Litigation: YES [ ] NO [ ]
How did Loss Occur: \_\_\_\_\_

Paid Loss: Indemnity \_\_\_\_\_ Medical \_\_\_\_\_ Expense \_\_\_\_\_
Incurred Loss: Indemnity \_\_\_\_\_ Medical \_\_\_\_\_ Expense \_\_\_\_\_
Was Equipment Involved? YES [ ] NO [ ] Description of Equipment \_\_\_\_\_
Did Insured make changes to operations as a result of loss? YES [ ] NO [ ] IF YES, What were the changes made?
\_\_\_\_\_

Claimant Name: \_\_\_\_\_ Date of Loss: \_\_\_\_\_
Job/Position at Time of Loss: \_\_\_\_\_ Open [ ] Closed [ ] Litigation: YES [ ] NO [ ]
How did Loss Occur: \_\_\_\_\_

Paid Loss: Indemnity \_\_\_\_\_ Medical \_\_\_\_\_ Expense \_\_\_\_\_
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How did Loss Occur: \_\_\_\_\_

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 Job/Position at Time of Loss: \_\_\_\_\_ Open  Closed  Litigation: YES  NO   
 How did Loss Occur: \_\_\_\_\_

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Paid Loss: Indemnity \_\_\_\_\_ Medical \_\_\_\_\_ Expense \_\_\_\_\_  
 Incurred Loss: Indemnity \_\_\_\_\_ Medical \_\_\_\_\_ Expense \_\_\_\_\_  
 Was Equipment Involved? YES  NO  Description of Equipment \_\_\_\_\_  
 Did Insured make changes to operations as a result of loss? YES  NO  IF YES, What were the changes made?  
 \_\_\_\_\_

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[If more losses are to be reported, copy this page to complete supplemental information](#)