

WORKERS' COMPENSATION - Temporary Staffing Supplemental Application

Applicant Name: _____
Applicant Primary Contact: _____ **Phone:** _____
Email: _____ **Website:** _____
Descriptions of Operations _____

Premium, Payroll and Experience Mod History

Please fill in the correct amount for each of the following:

	Expiring Year	Prior (1)	Prior (2)	Prior (3)	Prior (4)
Premium	_____	_____	_____	_____	_____
Payroll	_____	_____	_____	_____	_____
Experience Mod	_____	_____	_____	_____	_____

GENERAL APPLICANT INFORMATION

- What is the percentage of your anticipated annual growth for the upcoming year? _____
 Details: _____
- Are you a new Venture? Yes No
- Have you conducted business in your present territory for at least 3 years? If no, provide details. Yes No
 Details: _____
- Do you provide any assignments that are not temporary in nature (i.e. that do not have an end date)? Yes No
 If yes, explain: _____
- Are you required to be licensed or register as a PEO (Professional Employer Organization) in any of the states in which you operate? Yes No
- Do you provide any PEO services? If yes, provide details. Yes No

- Are there any other commonly owned businesses that are separately insured? Yes No
 If yes, provide details: _____
- Are there any states in which you operate that are covered elsewhere? Yes No
 If yes, provide details: _____
- Do you hire day laborers? If yes, provide details: Yes No

- Do you provide group transportation? If yes, provide details: Yes No

- 11 Do you employ 100 or more workers at any single work location? If yes, provide details: _____ Yes No
- 12 Do you have any outstanding WC premium or audit issues from the last three policy terms? If yes, provide details: _____ Yes No
- 13 Do you supply workers to construction operations in California? Yes No
- 14 Do any of your clients have exposures to Maritime operations subject to the USL&H Act, the Admiralty Law or the Outer Continental Shelf Lands Act? Yes No
- If yes, provide details: _____
- 15 Do any of your clients have exposures to the following Acts: Migrant and Seasonal Agricultural Worker Protection Act, Federal Employers' Liability Act, Federal Coal Mine Health & Safety Act, Defense Base Act? Yes No
- If yes, provide details: _____
- 16 Do you have foreign travel exposures? Yes No
- If yes, provide details concerning countries, duration, and number of employees. _____
- _____
- _____
- 17 Do you accept other temporary staffing agencies as clients (i.e. piggyback arrangements)? Yes No
- If yes, provide details and payroll associated with these clients. _____
- _____
- _____

EMPLOYEE SCREENING

Does your New Hire Program include the following:

- 1 Formal written job application Yes No
- 2 Criminal Background Checks Yes No
- 3 Reference checks Yes No
- 4 Motor Vehicle checks on drivers Yes No
- 5 Job experience & placement certification requirements Yes No
- 6 Pre-employment physicals Yes No
- 7 Pre-employment drug testing Yes No
- 8 Probationary period Yes No
- 9 Minimum Experience Requirements Yes No
- 10 Any additional information. If yes, provide details. Yes No

Details:

EMPLOYEE BENEFITS

Does your Employee Benefits Program include the following:

- 1 Health Insurance Yes No
- 2 Long-Term Disability Yes No
- 3 Short-Term Disability Yes No
- 4 Paid Vacation Days Yes No
- 5 Paid Sick Days Yes No
- 6 Employee Assistance Program Yes No

Details:

CLIENT INFORMATION

Average Number of New Clients added Annually? _____

Client Exposure Breakdown

(List the number of clients you have for each industry and the total number of employees assigned to each industry.)

	# of Clients	# of Employees		# of Clients	# of Employees
Light Industrial:			Wholesale / Retail:		
Heavy Industrial:			Clerical (Professional):		
Construction (Trade):			Clerical (General):		
Construction (General):			Medical:		

Total # of Full-Time Office Staff: _____

Total # of Temporary Placements Last Year: _____

of W2's: _____

1099's: _____

Do you require Independent Contractors Yes No
to carry their own WC coverage? If no explain reason:

Profile of the Five Clients with the Highest Number of Employees You Provide:

Customer Name	Description of work performed by your employees	Class Code	State	Payroll	Clients # of Employees	# of Temp

CLIENT SCREENING

- 1 Do you have established criteria for new client selection? If yes, provide details. Yes No
- 2 Do you complete job hazard assessments for all new clients or new tasks? If yes, provide details. Yes No

Details:

- 3 Do you have procedures in place to eliminate clients for poor safety practices or loss experience? Yes No
- 4 Do you review the client's new worker orientation procedure? Yes No
- 5 Do you or the client provide employees with a description of the job assignment? Yes No
- 6 Do you inspect worksites for safety "prior" to employee placement? Yes No
- 7 Do you have a procedure to conduct periodic client reviews? If yes, provide details. Yes No
- 8 Do you or the client provide safety training? If yes, provide details. Yes No

SAFETY MANAGEMENT BY APPLICANT

Does your Safety program include the following:

- 1 Written Safety Plan Yes No
- 2 Full time safety director. If yes, provide name and title. Yes No
- 3 Safety committee Yes No
- 4 Accident investigation Yes No
- 5 Employer provided safety equipment Yes No
- 6 Employee training for lifting, ergonomics, universal precautions Yes No
- 7 Employee safety meetings Yes No
- 8 Loss Control/Safety incentives Yes No
- 9 Light duty / early return to work Yes No
- 10 Random drug testing program Yes No

Details:

CLAIMS MANAGEMENT AND REPORTING

Does your Claims Management program include the following:

Details:

- | | |
|---|--|
| 1 Full time claims manager | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 Claims fraud investigation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 Established injury reporting procedures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4 Require all WC claims to be reported within 24 hrs. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5 Drug testing after an injury occurs. If yes, provide details on procedure. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6 A process to identify claims frequency and claims trends | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7 Mid term monitoring and reporting of trends in claim frequency and severity | <input type="checkbox"/> Yes <input type="checkbox"/> No |

APPLICANT SIGNATURE

Notice: This application is for the purpose of obtaining a quotation and does not bind the applicant or the Company to provide the insurance. The Undersigned declares that to the best of his/her knowledge, the statements set forth herein are true. If the information supplied herein changes between the date completed and the effective date of the insurance, the undersigned shall notify the Company of the changes and the Company reserves the right to modify or withdraw any offer for insurance.

Fraud Warning: 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, conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject such person to criminal and civil penalties.

Applicant Signature: _____ **Date:** _____