WORKERS COMPENSATION APPLICATION

General Information		
Legal Name		
☐ Corporation /LLC ☐ Partnership ☐ Individual ☐ Joint Venture ☐ Subsidiary ☐ Other		
Do you operate under a d.b.a? ☐ Yes ☐ No	d.b.a. Name	
Contact Name /Title		
Mailing Address		
City	State	Zip
Premise Address		
City	State	Zip
Phone#:	Fax#:	Cell #:
Web Address:	Email Address:	
Year Established:	Federal ID#:	
*Coverage Currently In Force? ☐ Yes ☐ No	Coverage Term From:	to

State Nature of Business and Description of Business Operations

List Major Owners / Shareholders		
Name	Title	% Ownership
1.		
2.		
3.		

Policy Information		
Year	Total Payroll	Total premium
Current	$	$
1st Prior	$	$
2nd Prior	$	$
3rd Prior	$	$

Payroll Information			
Position / Class code	Payroll per class	Expiring rate	# of FT/PT emp.
1.	$	$	
2.	$	$	
3.	$	$	
4.	$	$	

Operations and Benefits	
Years in business? Hours of operation-	# of Shifts -
Is there a driving/delivery exposure? Yes / No	Radius of operations/travel: <50 miles 50-100 100+
If yes, what is frequency: Daily Weekly Other:	Any group transportation of employees? Yes / No
Are vehicles company owned? Yes / No	If yes, how provided? car Truck Van Bus
If yes, are vehicles taken home? Yes / No	# of employees transported per vehicle
# Of vehicles? # Of drivers?	# of vehicles used to transport
Vehicle/fleet maintenance program? Yes / No	Frequency: Daily Weekly Monthly
If yes, who does the servicing? Outside vendor In-house mechanics Other:	
# of employees: Full time Part-time Seasonal Volunteers	
Any day laborers or temporary/employee leasing? Yes / No	Other:
If yes, please provide details on separate page.	Paid Sick Leave? Yes / No
% of union employees % of non-union	
Retirement / Pension plan? Yes / No Does employer contribute? Yes / No	
Group medical provided? Yes / No	% of employees enrolled
If yes, name of healthcare provider -	% paid by employer
Do you use a specific medical provider to treat injured employees? Yes / No	
If yes, Clinic Physician Emergency Room Other:	

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CPR training provided? Yes / No		RTW Program? Yes / No	
# of employees certified?		Does it include salary continuation Yes / No	
Hiring Practices – Employee Selection - Claims			
Written Application?	Yes / No	Pre-hire drug testing?	Yes / No
Reference Checks?	Yes / No	Post Accident drug testing?	Yes / No
Pre/post emp. Physicals?	Yes / No	MVR Checks?	Yes / No
Orthopedic back testing?	Yes / No	Audio hearing tests?	Yes / No
Formal job descriptions on file? Yes / No		Do you have a formal written accident report? Yes / No	
Are personnel files documented for pre-existing injuries: Yes / No		Are there set procedures for reporting claims? Yes / No	
Average claim reporting time frame -		Any Interchange of labor? Yes / No	
Is job specific training provided? Yes / No		If yes, please explain Another business Subsidiary	
Employee Orientation Program? Yes / No		Between departments Other:	
If yes, is the orientation Verbal only? Verbal and Documented?			
Supervisor to Employee ratio - Better than 4-1 5-1 6-1 7-1 >7-1			
Subcontractors used? Yes No If yes, for what purpose?			
If yes, are certificates of insurance obtained and kept on file? Yes / No			
Independent contractors used? Yes / No If yes, for what purpose?			
If yes, how are they paid? 1099's? Other? Please explain-			
Safety Program and Organization – Work premises and Environment			
Are owners active in daily operations?	Yes / No	If yes, are they excluded from coverage?	Yes / No
Active injury & illness prevention program?	Yes / No	Has loss control services been performed in the last year?	Yes / No
Active safety incentive program?	Yes / No	Has Cal/OSHA visited or cited your business in the last year?	Yes / No
If yes, does it encompass all employees?	Yes / No	If yes, please provide explanation on separate page.	
What type of incentive?		Are safety meetings conducted?	Yes / No
Do employees receive safety training/orientation?	Yes / No	If yes, how often? Daily Weekly Monthly Quarterly	
If yes, is the training - Formal / Documented Informal		Other:	
Do you have a safety director or risk manager?	Yes / No	Name and title:	
If yes, is the position full time or an additional responsibility of another employee?			
MSD Sheets available for all chemicals used?	Yes / No / N/A		
Any material handling exposures?	Yes / No	If yes, please explain	
Any manual lifting exposures?	Yes / No	If yes, <25 lbs. 25-40 Over 40+ Please explain:	
Forklifts owned or operated?	Yes / No	If yes, annual certification? Yes No	
Are all machines/equipment properly guarded?	Yes / No / N/A	Condition of equipment? New Good Average	
Written Lock out / tag out procedures in place?	Yes / No / N/A		
Are all equipment operators trained/ certified?	Yes / No / N/A		
What is the maximum height at which you will work?			
What is used? Ladder Scaffolding Scissor lifts N/A			
Personal protection equipment provided?	Yes / No / N/A	What types of PPE?	
Automotive Services			
Any towing services provided?	Yes / No		
If yes, any contract towing?	Yes / No		
Any road repair assistance?	Yes / No	If yes, 24 hour exposure?	
Any fueling operations?	Yes / No		
Any security/surveillance cameras on premises?	Yes / No		
Any test driving of customers' vehicles?	Yes / No		
Any transportation of customers?	Yes / No		
Are employees ASE trained and certified? Yes No If yes, how many employees?			
Manufacturing – Machine Shops			
Any punch press or press brake machinery/equipment? Yes / No		Machine Guarded: Point of operation Drive Mechanism	
Age of machinery: <2 yrs 2-5 yrs 5-10 yrs 10+ yrs		Accessible moving parts guarded on machinery/equipment? Yes / No	
Types of machines (must equal 100%) - Heavy __ Mid __ Light __		Any Computer Network Controlled (CNC) machinery? Yes / No	
% of off-premise operations: __ If yes, where/what for?			
Is building properly ventilated? Yes / No		Is proper dust collection system in place? Yes / No	
Notes:			

Signature of Applicant: _____ Date: _____