HEALTHCARE SUPPLEMENTAL APPLICATION

NAME OF APPLICANT: _____
MAILING ADRESS: _____
CITY / STATE / ZIP: _____

GENERAL EXPOSURE INFORMATION

Description of Operations: _____

Number of years in business under the above name / operation: _____
Prior Workers Compensation Coverage: ☐ Yes ☐ No
Name of Current Carrier _____
If none, provide the owner(s) experience in managing or operating this type of business:

_____

Any other entities owned by this applicant? ☐ Yes ☐ No (if yes, please explain)
_____

What percentage of work is performed in the following categories? **(must equal 100%)**

Assisted Living Center _____
Home Health Care _____
Home Infusion _____
Homemaker Services _____
Hospice _____
Other (describe) _____

Hospital Services (inpatient) _____
Hospital Services (outpatient) _____
Pharmacy Services _____
Physical Therapy _____
Staffing Services (temp/perm) _____

Based on the above work exposures, what is the break down of employees under Direct Payroll (W-2 filed) and/or Subcontracted (1099 or other) according to the following jobs performed? (include full / part time totals)

	Number Employed	Number Contracted	Hospital Percent	Nursing Home	Client's Home
Aides					
LPN's					
RN's					
Nurse Practitioner					
Other (specify)					

Does the insured utilize contracted / subcontracted staffing for any services? ☐Yes ☐No
(if yes, please answer sections below)

a. Percentage of annual exposure (based on cost of labor / material) _____
b. Type of work contracted on normal basis _____
c. Are Certificates of Insurance maintained for the Workers Comp coverage? ☐ Yes ☐ No
(if no, payroll for this exposure will be picked up at audit)

Does applicant have a formal safety program incorporated in operations? ☐ Yes ☐ No

Does applicant incorporate any of the following?

Periodic Safety Meeting(s), documented?	☐Yes ☐No
Comments:	
Written Safety Inspection Program?	☐Yes ☐No
Comments:	
Formal Lift Protection Plan?	☐Yes ☐No
Comments:	
Formal Fall Protection Plan?	☐Yes ☐No
Comments:	
Pre Hire Drug Testing?	☐Yes ☐No
Comments:	
Post Accident Drug Testing?	☐Yes ☐No
Comments:	
Second Injury Questionnaire Completed?	☐Yes ☐No
Comments:	

If No to above, is applicant willing to implement safeguards into program? ☐ Yes ☐ No

Are all visits to patients' homes documented by employees accurately with report logs? ☐ Yes ☐ No

If Yes, how often are reports submitted to management? _____

What specific types of training do employees receive? _____

Is updated training provided on a regular basis? ☐Yes ☐No

If so, please advise how often. _____

What types of vehicles are used in the insured's operation?

Make: _____ Model:_____ How many? _____

How often serviced? _____ By whom? _____ Travel logs maintained? ☐ Yes ☐ No

MVR checks? ☐ Yes ☐No Reviewed on a regular basis ☐Yes ☐No How often? _____

What is the company policy for maximum allowable moving vehicle accidents?

_____

Are these company vehicles or employees' personal auto? _____

What is the mile radius of operation? _____ How often traveled? _____

Are travel logs maintained? ☐Yes ☐No

Are background checks performed on prospective new professional hires? ☐Yes ☐No

New non-professional hires? ☐Yes ☐No

What is the maximum allowable ratio between ambulatory / non-ambulatory patients?

_____

Please advise of any specific accreditation(s) held by the company and / or professional employees.

_____

_____

_____

Signature of Applicant: _____

(must be completed by an owner, officer or authorized representative)

Name & Title : _____

Date: _____

Signature of Agent: _____

Date: _____