Healthcare Supplemental Application

Applicant name:

FEIN:

Number of years in business:

Applicant's Website address:

Please attach the following documents to this supplemental application:

- ☐ Completed Acord 130
- ☐ Currently valued workers' compensation loss runs for the current and previous four years
- ☐ Currently valued commercial auto loss runs for the current and previous four years
- ☐ Copy of the most recent annual and year-to-date financial statements (audited if available).

Employee Profile

Occupation	# Full Time	# Part Time	Average Hourly Wage
Administrative			
Home Health Aides			
Licensed Practical Nurses			
Medical Doctors			
Personal Care Aides			
Pharmacists			
Physical Therapists			
Radiologists			
Registered Nurses			
Other			
Describe other:			

Please indicate where your employees perform their work:

Nursing Homes	%	Community Residences	%	Hospitals	%
Doctors Offices	%	Day Care Setting	%	Prisons	%
Private Home/Apt	%	Corporate Offices	%	Clinics	%
Other	%	Describe other:	%		%

On average how many locations/assignments does each employee travel to per day? _____

Are independent contractors being used? ☐YES ☐NO If so, how many? _____

Do you utilize temporary staffing or employee leasing/PEO services? ☐YES ☐NO

Do employees primarily cook, clean, bathe, groom or perform general housekeeping? ☐YES ☐NO

Indicate percentage of volunteers in workforce: _____%

Indicate annual turnover rate: _____%

Percentage of employees working in the following types of facilities:

For-Profit_____%, Non-Profit_____% Government_____%

Employee Selection

Do you perform personal interviews with every candidate? ☐YES ☐NO
Do you validate work history for every candidate? ☐YES ☐NO
Do you perform reference checks on applicants? ☐YES ☐NO
Do you verify certifications/licenses of applicants? ☐YES ☐NO
Do you perform criminal background checks on applicants? ☐YES ☐NO
Describe how you verify legal status to work:
Do you utilize pre-employment integrity and/or psychological testing? ☐YES ☐NO
If YES, which one?
Do you utilize a post-offer medical questionnaire? ☐YES ☐NO
If so, please provide a copy.
Do you perform pre-employment fit-for-duty medical evaluations? ☐YES ☐NO
Drug testing of applicants is performed:
Prior to employment on all employees whether or not requested by a client ☐YES ☐NO
Prior to employment only if requested by the client ☐YES ☐NO
After an accident ☐YES ☐NO
Are alcohol tests performed after an accident? ☐YES ☐NO

Driving Related Questions:

Do employees drive personal vehicles? ☐YES ☐NO company vehicles? ☐YES ☐NO

How many miles per day per employee are driven? _____ miles
What is the typical and maximum radius (in miles) of any of your traveling employees:
Typical _____ Maximum _____

Are Motor Vehicle Records (MVR) checked for all employees who drive as part of their job? ☐YES ☐NO
If yes:
MVR's at verified at time of hire: ☐YES ☐NO
MVR's verified every 6 months after hire: ☐YES ☐NO
Copies of MVR's maintained in personnel files: ☐YES ☐NO

Driving employees are held to the following standards:
No more than _____ minor violations and at fault accidents in the last 3-year period.
No more than _____ major violations (DUI, reckless driving, eluding, etc) in the last 3-year period
Do you have an enforced seatbelt policy? ☐YES ☐NO
If yes, please attach policy ☐ATTACHED
Do you have an enforced cell phone use and texting policy? ☐YES ☐NO
If yes, please attach policy ☐ATTACHED

Safety and Claims Management Program

Do you have a Safety Director and/or Claims Manager? ☐FULL TIME ☐PART TIME ☐NO
If YES, attach job description or describe their duties. ☐ATTACHED

Please attach your safety-training program. ☐ATTACHED
Do you have a policy that states no manual lifting of patients? ☐YES ☐NO
Attach or describe your footwear program/policy: ☐ATTACHED

Please attach your new patient intake process. ☐ATTACHED
Are worksite safety evaluations conducted and are they documented? ☐YES ☐NO

Are crime statistics reviewed prior to sending employees to a residential location? ☐YES ☐NO

Who conducts worksite safety inspections?

Please attach your Return-to-Work program. ☐ATTACHED

Have detailed light duty job descriptions been developed? ☐YES ☐NO

Do you bring the worker back to work when the doctor has provided a:

☐ limited release ☐YES ☐NO

☐ full release ☐YES ☐NO

The undersigned Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate, or omit any material facts.

The Applicant agrees to notify Work First Casualty Company of any material changes in the answers to the questions on this Supplemental Application which may arise prior to the effective date of any policy issued pursuant to this Supplemental Application and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at the sole discretion of Work First Casualty Company.

Notwithstanding any of the foregoing, the Applicant understands that Work First Casualty Company is not obligated or under any duty to issue a policy of insurance based upon this information. The Applicant also agrees to use commercially reasonable efforts to provide light duty to all its injured workers until such time as they reach maximum medical improvement.

Applicant Signature (required): _____

Name: Date:

Producer Signature (required): _____

Name: Date: