

NEGLEY ASSOCIATES

UNDERWRITING MANAGERS

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Supplemental Workers' Compensation Application

Named Insured: _____ **Website:** _____

Policy Year	Policy Period	Premium	Total Audited Payroll	Insurance Carrier	Experience Mod
Expiring Year					
1 st Prior Year					
2 nd Prior Year					
3 rd Prior Year					
4 th Prior Year					

Number of Employees: Full Time _____ Part Time _____ Temporary _____

Number of Volunteers: Full Time _____ Part Time _____ Seasonal _____

Briefly describe volunteer's responsibilities: _____

Are there greater than 100 employees in any one location? Yes No

If you answered "yes", please complete the following table:

Instructions: For each location, list the number of Floors for each location and the # of employees for each floor as well as for the entire location
(Please write here or attach schedule.)

Location #	Description & Address of Property	# of Stories	Payroll	Number of Employees
1	Example Property	5	\$1,000,000	50 per floor; or 10- floor 1, 20- Floor 2, etc.

General Information

Explain all "yes" responses (attach separate sheet if necessary)	YES	NO	Explain all "yes" responses (attach separate sheet if necessary)	YES	NO
a. Has there been a name change or a consolidation, merger or other ownership change during the past three years? If yes, attach a separate signed ownership statement on employer's percentage of stock, and date of change.	<input type="checkbox"/>	<input type="checkbox"/>	b. Do you or any commonly owned or managed enterprises owe any unpaid workers compensation insurance premiums?	<input type="checkbox"/>	<input type="checkbox"/>
c. Has any owner ever been in business under a different name? If yes, give name(s) and date(s) of operation.	<input type="checkbox"/>	<input type="checkbox"/>	d. Has any insurance company ever canceled your workers compensation policy for nonpayment or for any other reason?	<input type="checkbox"/>	<input type="checkbox"/>
e. Has any owner filed for bankruptcy? If yes, give date and state of filing.	<input type="checkbox"/>	<input type="checkbox"/>	f. Is there any USL&H or other similar federal exposures?	<input type="checkbox"/>	<input type="checkbox"/>

Hiring Practices and Benefits Information:

	YES	NO		YES	NO
Are written applications used?	<input type="checkbox"/>	<input type="checkbox"/>	Do you do drug screening (check those that apply):		
Are reference checks performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> All-Employees <input type="checkbox"/> Drivers only <input type="checkbox"/> None		
Are employees who perform repetitive motion duties rotated throughout the day?	<input type="checkbox"/>	<input type="checkbox"/>	Is group medical coverage provided?	<input type="checkbox"/>	<input type="checkbox"/>
Does the insured use temporary workers?	<input type="checkbox"/>	<input type="checkbox"/>	Are employees provided paid sick leave?	<input type="checkbox"/>	<input type="checkbox"/>
Name of WC carrier for the temp. firm? _____			Paid vacation?	<input type="checkbox"/>	<input type="checkbox"/>

Management and Safety Practices:

	YES	NO	
Do you have a formal safety program?	<input type="checkbox"/>	<input type="checkbox"/>	
Are safety meetings or training provided?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other Composed of <input type="checkbox"/> Management <input type="checkbox"/> Supervisors <input type="checkbox"/> Workers
Do you perform routine safety inspections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
Do you have a Safety Incentive Program?	<input type="checkbox"/>	<input type="checkbox"/>	
Are safety issues communicated to employees?	<input type="checkbox"/>	<input type="checkbox"/>	Method _____
Are supervisors accountable for employee safety?	<input type="checkbox"/>	<input type="checkbox"/>	
Are accident investigations performed?	<input type="checkbox"/>	<input type="checkbox"/>	By <input type="checkbox"/> Executive Director <input type="checkbox"/> Safety Director <input type="checkbox"/> Owner <input type="checkbox"/> Other
Does the insured have lock out / tag out procedures?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use any mechanical lifting devices?	<input type="checkbox"/>	<input type="checkbox"/>	Description _____
Is the use of personal protective equipment enforced?	<input type="checkbox"/>	<input type="checkbox"/>	Description _____
Do you have a designated medical provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physician <input type="checkbox"/> Clinic <input type="checkbox"/> Other
Has your medical provider reviewed operations to assist with early return to work program?	<input type="checkbox"/>	<input type="checkbox"/>	

RISK MANAGEMENT INFORMATION

- a. Are independent contractors required to carry their own liability and workers' compensation insurance? Yes No
- b. Are copies of the insurance certificates obtained annually and kept on file? Yes No
- c. Does work performed by uninsured contractors exceed 15% of the receipts? Yes No
- d. If the insured has a formal safety program in operation please indicate applicable safety elements in 'e' below
- e. Please indicate which of the following **safety program elements** are currently operational:
- | | | |
|---|---|--|
| <input type="checkbox"/> Driver Safety Program | <input type="checkbox"/> Labor/Management Safety Committee | <input type="checkbox"/> Return to Work/Modified Duty |
| <input type="checkbox"/> Patient Handling/Transfer Training | <input type="checkbox"/> Mentoring process for new employees | <input type="checkbox"/> Screening process for new hires |
| <input type="checkbox"/> New Employee Orientation | <input type="checkbox"/> Personnel Evaluations include "safety" | <input type="checkbox"/> Driver Training/Travel Logs |
| <input type="checkbox"/> Management Involvement in safety (describe if checked) | | |
- _____
- _____

Vehicle / Driving Exposure:

			YES	NO
Do you provide group transportation for clients or employees? (If yes, please complete questions below)			<input type="checkbox"/>	<input type="checkbox"/>
Number of Clients _____	Number of Daily Trips _____	Purpose of Transportation _____		
Number of Employees _____	Number of Daily Trips (employees only) _____			
Do employees transport clients in personal or company cars during the workday? If yes, how often _____			<input type="checkbox"/>	<input type="checkbox"/>
And what is the purpose of the transportation? _____				
Are Motor Vehicle Records (MVR) checked annually for all employees who drive as part of their job?			<input type="checkbox"/>	<input type="checkbox"/>
Number of Company Vehicles _____		Delivery Provided	<input type="checkbox"/>	<input type="checkbox"/>
Number of Company authorized drivers _____		Participate in DMV "Pull" Program	<input type="checkbox"/>	<input type="checkbox"/>
Radius of Travel for Company Vehicles _____	Miles _____	Vehicle and Equipment Inspected: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
Vehicles and Equipment Serviced By	<input type="checkbox"/> Employees <input type="checkbox"/> Outside Mechanics			

