

## Supplemental Application – Workers’ Compensation

Name of Applicant: \_\_\_\_\_ Company Website: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
 Any change to the Normal Anniversary Date? \_\_\_\_\_ FEIN (please include all): \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_ Is the applicant a member of ISRI?  yes  no  
 Has the applicant had any OSHA citations in the last five years?  yes  no Is the applicant CAR Designated?  yes  no  
 Has the applicant had any EPA citations in the last five years?  yes  no Is the applicant RIOS Designated?  yes  no  
 Has the applicant had any occupational disease (OD) claims in the last five years?  yes  no  
 Number of years employer has had Workers’ Compensation insurance: \_\_\_\_\_

Policy Year	Premium & Carrier	Payroll by State and Class Code
Expiring Year		
1 <sup>st</sup> Prior Year		
2 <sup>nd</sup> Prior Year		
3 <sup>rd</sup> Prior Year		
4 <sup>th</sup> Prior Year		

Total FT EE: \_\_\_\_\_ Total PT EE: \_\_\_\_\_ Total Full Time Equivalents: \_\_\_\_\_ Hours of operation: \_\_\_\_\_  
 Number of authorized drivers: \_\_\_\_\_ Number of vehicles: \_\_\_\_\_  
 Number of W2 forms issued last year: \_\_\_\_\_ Average hourly wage in governing class: \$ \_\_\_\_\_  
 Is group (3+) transportation provided?  yes  no Are there greater than 50 employees in any one location?  yes  no  
 If so, identify each location and provide total head count and payroll per location:  
 Does the applicant have any foreign Workers’ Compensation exposure?  yes  no  
 If yes, please provide head count and number of days visited by country: \_\_\_\_\_

### Financial:

For the most recent fiscal year-ended, please provide the following:  
 Net income: \_\_\_\_\_ Gross Revenue: \_\_\_\_\_  
 Total Assets: \_\_\_\_\_ Gross Revenue - Prior Year: \_\_\_\_\_  
 Total Equity: \_\_\_\_\_ Gross Revenue – Forecasted Current FY : \_\_\_\_\_  
 Has the applicant at any time files for Chapter 7 or Chapter 11 bankruptcy? (if so, please provide details)  yes  no

### Premises:

Are interconnected smoke detectors in place?  yes  no Is the building sprinklered?  yes  no  
 Are fire extinguishers present?  yes  no Are there multiple means of egress?  yes  no  
 Do security cameras record daily operations?  yes  no Is there a fire/emergency evacuation plan in place?  yes  no  
 Are emergency eyewash stations present?  yes  no Are security cameras in use in work areas?  yes  no  
 Is emergency lighting in place?  yes  no Is there adequate ventilation in work areas?  yes  no  
 Years at current location: \_\_\_\_\_ Age of building occupied: \_\_\_\_\_  
 Building is  owned  leased Equipment condition:  New  Good  Other \_\_\_\_\_  
 Number of stories: \_\_\_\_\_ Number of Occupied Buildings: \_\_\_\_\_

### Benefits:

Are all employees eligible?  yes  no If not, who is eligible?: \_\_\_\_\_  
 Is group health insurance provided?  yes  no Percentage of total employees participating: \_\_\_\_\_  
 Name of healthcare provider: \_\_\_\_\_ Percentage paid by employer: \_\_\_\_\_  
 Is disability insurance provided?  yes  no Is sick paid leave provided?  yes  no  
 Is paid vacation provided?  yes  no Is a retirement/pension plan provided?  yes  no

### Hiring practices:

Are written applications used?  yes  no Do any employees work from home?  yes  no  
 Are reference checks performed?  yes  no Are criminal background checks performed?  yes  no  
 Is MVR screening criteria in place?  yes  no Are personnel files documented for pre-existing injuries?  yes  no  
 Are motor vehicle record checks performed?  yes  no Is there a new hire orientation program?  yes  no

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Is any leased, volunteer, or temporary labor used?  yes  no  
 Is drug testing part of the hiring process?  yes  no  
 Is a drug/substance abuse program available?  yes  no  
 Is the labor force unionized?  yes  no  
 Number of employees under the age of 18 or over 60:  
 Full Time:      Part Time:

Does orientation include a review of safety / Workers’ Comp?  yes  no  
 Is orthopedic back screening provided?  yes  no  
 Is physician screening provided?  yes  no  
 Is any day labor or temp staffing used?  yes  no  
 What is the employee : supervisor ratio?:

### Risk Management:

Is there a formal safety incentive program in place?  yes  no  
 Is RTW modified duty provided to all EE?  yes  no  
 Is a written safety program in place?  yes  no  
 Does the insured have a full time risk manager on staff?  yes  no  
 Are safety meetings or training provided?  yes  no  
 Is post-accident drug / substance abuse testing practiced?  yes  no  
 Are subcontractors/independent contractors used?  yes  no  
 Does the employer conduct annual MVR checks?  yes  no  
 Does the employer agree to participate in the Carrier’s medical provider network?  yes  no

Is a formal return to work (RTW) program in place?  yes  no  
 Does RTW includes full wages?  yes  no  
 Are owners active in daily operations?  yes  no  
 Is an IIPP in place and enforced?  yes  no  
 Are all workplace injuries investigated by a safety committee?  yes  no  
 Is all machinery guarded in compliance w/ OSHA standards?  yes  no  
 If so are certificates of Work Comp insurance obtained?  yes  no

### Operations:

Where do you source the scrap material which you process?

How is the scrap material which you process delivered to your facilities?

How is the scrap material sorted at your facility?

What tools and practices are used to screen scrap material for radioactivity and other hazardous waste?

Please give a brief description of how you process scrap material into your finished product:

How is your finished product shipped to your customer?

What types of scrap material does your operation process? Please check all that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ferrous Scrap Metals     | <input type="checkbox"/> Textiles           | <input type="checkbox"/> Liquid Materials             |
| <input type="checkbox"/> Non-ferrous Scrap Metals | <input type="checkbox"/> Rubber             | <input type="checkbox"/> Household Garbage            |
| <input type="checkbox"/> Aluminum cans            | <input type="checkbox"/> Auto Parts         | <input type="checkbox"/> Rare Earth / Precious Metals |
| <input type="checkbox"/> Plastic                  | <input type="checkbox"/> Electronics        | <input type="checkbox"/> Hazardous waste              |
| <input type="checkbox"/> Paper                    | <input type="checkbox"/> Construction Waste | <input type="checkbox"/> Batteries                    |
| <input type="checkbox"/> Glass                    | <input type="checkbox"/> Tires              | <input type="checkbox"/> Other (please describe)      |

Average driving radius:

Are personal vehicles used for company business?  yes  no

Are any company vehicles taken home at night?  yes  no

Is there any out of state travel?  yes  no

Is any work done off-site?  yes  no If so, please describe the activities along with the frequency of the work and what tools/equipment may be used.

What type of equipment is owned and or operated? **Please note the number of each that apply.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cranes              | <input type="checkbox"/> Roll-off container trucks | <input type="checkbox"/> Other shredder (please specify)  |
| <input type="checkbox"/> Front end loaders   | <input type="checkbox"/> Conveyor belts            | <input type="checkbox"/> Sweat furnace                    |
| <input type="checkbox"/> Bulldozers          | <input type="checkbox"/> Automated sorting lines   | <input type="checkbox"/> Incinerator                      |
| <input type="checkbox"/> Excavators          | <input type="checkbox"/> Manual sorting lines      | <input type="checkbox"/> Hydraulic shears                 |
| <input type="checkbox"/> Dump trucks         | <input type="checkbox"/> Fork lifts                | <input type="checkbox"/> Mechanical shears                |
| <input type="checkbox"/> Pickup trucks       | <input type="checkbox"/> Bailers / compactors      | <input type="checkbox"/> Cutting torches (please specify) |
| <input type="checkbox"/> Garbage trucks      | <input type="checkbox"/> Tow truck                 |   |
| <input type="checkbox"/> Semi-trailer trucks | <input type="checkbox"/> Auto Shredders            |   |

How often is equipment inspected?

Number of vehicles used for delivery:

Do employees ever ride outside of vehicles?  yes  no

Who inspects the equipment and what qualifications does this person have?

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If your operation includes the collection of roll off containers please describe this operation and the associated safety controls in place. Please include mention of loading/unloading and tie down:

Does your operation perform torch cutting or welding?  yes  no If so, please describe your safety protocols for this practice. Also note the safety controls in place for open flame cutting or welding near flammable materials:

Does your facility actively screen for the following materials?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anything containing PCB's (light ballasts, capacitors, transformers etc) | <input type="checkbox"/> Potentially radioactive material | <input type="checkbox"/> Airbags (sodium azide) |
| <input type="checkbox"/> Anything containing CFC's  | <input type="checkbox"/> Heavy metals                     | <input type="checkbox"/> Asbestos               |
|   | <input type="checkbox"/> Precious metals                  |   |

### Safety Training:

Has the applicant signed the ISRI Safety Pledge? yes  no

Are training programs in place for new and existing employees? yes  no  If yes, list all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> New Hire Orientation/ Safety Training                | <input type="checkbox"/> Mobile Equipment Safety                             |
| <input type="checkbox"/> Hazard Communication Training                        | <input type="checkbox"/> Forklift & heavy machinery operators are certified  |
| <input type="checkbox"/> Lock-Out /Tag-Out Training                           | <input type="checkbox"/> Emergency Evacuation                                |
| <input type="checkbox"/> Hazardous Substance Handling                         | <input type="checkbox"/> Driver Safety Training                              |
| <input type="checkbox"/> OSHA Blood borne pathogens safety (auto dismantlers) | <input type="checkbox"/> Prompt compliance with loss control recommendations |
| <input type="checkbox"/> Proper Use of Personal Protective Equipment          | <input type="checkbox"/> Other:  |
| <input type="checkbox"/> Strain Prevention / Proper Lifting Procedures        |  |

Frequency of Training:

### PPE Provided and or required:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Steel toe boots    | <input type="checkbox"/> Hardhat                  | <input type="checkbox"/> Safety belt / Back brace |
| <input type="checkbox"/> Gloves             | <input type="checkbox"/> Welder's apron           | <input type="checkbox"/> Respiratory equipment    |
| <input type="checkbox"/> Protective eyewear | <input type="checkbox"/> Welder's shield & helmet | <input type="checkbox"/> Other:                   |
| <input type="checkbox"/> Hearing protection | <input type="checkbox"/> Lifting straps           |   |

### Ergonomics program:

Is ergonomically flexible furniture used?  yes  no

Are employees who perform repetitive motion duties rotated to different tasks throughout the course of the day?  yes  no

Is worksite analysis conducted to identify jobs and workstations that contribute to cumulative trauma problems?  yes  no

Are conveyors and sorting lines set at a such a height to as to avoid bending, stooping, straining?  yes  no

### Large Loss History:

Has the insured had any losses greater than \$25,000 in the past five years?  yes  no

If yes, please provide details below.

Claimant Name:	Date of loss:
Position at time of loss:	<input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Litigated
Paid:	Indemnity: Medical: Expense:
Incurred:	Indemnity: Medical: Expense:
Did the insured make any changes in operations as a result of this loss? <input type="checkbox"/> yes <input type="checkbox"/> no	
Please explain:	

Prepared by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_