

Supplemental WC Questionnaire

Administered by: **Smith, Bell & Thompson, Inc.**

Please type or print clearly in ink. All sections must be completed fully. If you need more space, attach additional sheets as needed, using company letterhead. If you have been in operation for less than 3 years, please attach the resumes of the owners and/or managers. "You", "your", "applicant", and "company" all refer to the proposed named insured(s).

Insured Entity Name: _____

Proposed Effective Date of Coverage: _____

Federal Employee ID Number(s): _____

(If more than one entity/subsidiary, please attach description and % owned for each)

GENERAL INFORMATION

- 1) Is the applicant currently insured? Yes No
- 2) If so, are they currently insured in the Assigned Risk Pool? Yes No
- 3) Does the applicant use volunteers or donated labor? Yes No
- 4) Is the applicant a PEO, Employee Leasing Company, Temporary Staffing Agency, Labor Contractor, or otherwise supply employees to another employer on a contract, temporary or on call basis? Yes No
If "yes", please provide details. _____

5) What month and year did this business start? _____

6) How many years / months of direct health care related experience do the owners/proprietors have? _____

7) Have your operations ever been suspended by any local, state, or federal regulatory authority? Yes No
If yes, why? _____

8) Does the applicant have general liability & professional liability insurance in force? Yes No
If yes, Carrier?: _____ Effective Dates?: _____

- 9) Indicate employee annual turnover rate _____ %
- o Total # of Employees _____
 - o # of Full Time Professional Employees (RN, LPN, CPT, certified) _____
 - o # of Full Time Non-professional Employees _____
 - o # of Volunteers Annually? _____ or No Voluntary Labor
 - o Total Number of volunteer work hours annually?* _____

*# of volunteers x number of days x 8hr per day, round to the nearest hour.

- 10) Please indicate where your employees perform their work:
- | | |
|--|--|
| <input type="checkbox"/> Private Homes _____% | <input type="checkbox"/> Nursing Homes _____% |
| <input type="checkbox"/> Doctor's Offices _____% | <input type="checkbox"/> Hospitals _____% <input type="checkbox"/> *Community Residences _____% |
| <input type="checkbox"/> Clinic Setting _____% | <input type="checkbox"/> Corporate Offices _____% <input type="checkbox"/> *Other Locations _____% |
| <input type="checkbox"/> *Correctional Facilities (Penal Institutions –youth or adult, detention centers, 'boot' camps, etc.) _____% | |

*Please describe: _____

11) Do you have any **24 hour** employee exposures such as live-in-home employees, etc.? Yes No
If "yes", please provide details. _____

12) Please enclose any available informational brochures describing operations, locations, services, etc. See Attached.

13) Website Address: www. _____

- 14) What percentage % of your payroll is for:
- | | |
|--|--|
| <input type="checkbox"/> Youth or Residential housing risks _____% | <input type="checkbox"/> COED residential housing risks _____% |
| <input type="checkbox"/> Mentally handicapped _____% | <input type="checkbox"/> Alzheimer's patients _____% |
- No exposures in the above classes.

15) **BUSINESS OPERATIONS** - Check all that apply to your operations:

- | | | |
|--|---|--|
| <input type="checkbox"/> Home Health Care Provider | <input type="checkbox"/> Visiting Nurse Agency | <input type="checkbox"/> Supplemental Medical Staffing |
| <input type="checkbox"/> Hospice Provider | <input type="checkbox"/> Nurse Registry | <input type="checkbox"/> Medical Equipment Supplier |
| <input type="checkbox"/> Retail Pharmacy | <input type="checkbox"/> Closed Pharmacy | <input type="checkbox"/> Infusion Therapy Provider |
| <input type="checkbox"/> Rest Home / Senior Living | <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Physical Therapy / Occ. Health |
| <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> Crisis Response Team | <input type="checkbox"/> Substance Abuse Counseling |
| <input type="checkbox"/> Drug Treatment/Detox | <input type="checkbox"/> Inpatient Psychiatric Treatment | <input type="checkbox"/> Crisis Hotline |
| <input type="checkbox"/> Halfway House | <input type="checkbox"/> Onsite Pharmacy | <input type="checkbox"/> Crisis "shelters" |
| <input type="checkbox"/> Correctional Facility Nursing | <input type="checkbox"/> Correctional Facility Counseling | <input type="checkbox"/> Behavioral Problem Youth Counseling |
| <input type="checkbox"/> Other _____ | | |

16) **HISTORICAL PAYROLL & PREMIUM INFORMATION**

Year	Payrolls by Class Code / State	Expiring Premium / Carrier
2011		
2010		
2009		
2008		
2007		
2006		

17) **DRUG FREE POLICY**

- Have you published a statement notifying all employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited and specified the actions that will be taken against employees for violations of the prohibition? Yes No
- Do you require that each employee be given a copy of the drug free policy and as a condition of employment the employee must agree to abide by the terms of the statement? Yes No
- Do you require both pre-employment / and post-employment random drug testing? Yes No

18) **OSHA VIOLATION HISTORY**

Has the applicant been cited for any OSHA violations in the past 3 years? Yes No If yes, violation dates and citation details: _____

19) **SAFETY PROGRAM(S)**

- | | |
|---|--|
| <input type="checkbox"/> Formal Accident/Injury Investigations* | <input type="checkbox"/> Prompt compliance with Loss Control recommendations |
| <input type="checkbox"/> Labor/Management Safety Committee | <input type="checkbox"/> Safety Incentive Program |
| <input type="checkbox"/> Patient Handling/Transfer Training | <input type="checkbox"/> Proper Lifting Techniques |
| <input type="checkbox"/> Mentoring process for new employees* | <input type="checkbox"/> New Employee Orientation* |
| <input type="checkbox"/> Personnel Evaluations include "safety" | <input type="checkbox"/> Driver Training/Travel Logs |
| <input type="checkbox"/> Return to Work/Modified Duty | <input type="checkbox"/> Formal background checks for new hires |
| <input type="checkbox"/> Functional testing of new hires | <input type="checkbox"/> Management Involvement in Safety (describe); |
| <input type="checkbox"/> Blood Borne Pathogens | <input type="checkbox"/> New Employee Orientation* |

*Describe: _____

