

# WorkComp**GUARD**<sup>SM</sup>

## Supplemental WC Questionnaire

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

### Instructions:

- 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

Firm Name: \_\_\_\_\_  
(If more than one entity/subsidiary, please attach description and % owned for each)

- 1) How long has the applicant been in business under this name? \_\_\_\_\_ If less than 3 years, provide a copy of the resume of the owner/manager of this entity.
- 2) Is the applicant currently in the assigned risk pool?  Yes  No
- 3) Does the applicant own, operate or lease any watercraft or aircraft?  Yes  No
- 4) Does the applicant use volunteers or donated labor?  Yes  No  
If "yes", what is the percentage of donated labor as compared to paid labor? \_\_\_\_\_
- 5) Does the applicant provide employee health plans?  Yes  No (If yes, indicate type of plan, outline participation, & eligibility): \_\_\_\_\_  
\_\_\_\_\_
- 6) 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 explain: \_\_\_\_\_  
\_\_\_\_\_
- 7) Does the applicant have exposures (excluding outside sales and/or clerical payroll) in more than 7 states?  Yes  No
- 8) Has the applicant incurred any single loss greater than \$25,000 over the last 3 years?  Yes  No
- 9) Has the applicant's WC coverage been cancelled in the past year for underwriting reasons? (N/A in MO)  Yes  No  
If "yes", please explain: \_\_\_\_\_
- 10) Has the applicant's WC coverage been cancelled for nonpayment within the last 3 years? (N/A in MO)  Yes  No
- 11) Is there workers compensation coverage currently in force?  Yes  No
- 12a) Number of employees traveling outside of the U.S. per year: \_\_\_\_\_ 12b) Number of days worked per employee outside of the U.S. per year: \_\_\_\_\_ 12c) Choose Repatriation Limit:  \$5,000  \$10,000  \$15,000  \$20,000  
 \$25,000
- 13) Are certificates of Workers' Compensation insurance maintained for all work performed by sublet labor?  Yes  No
- 14) Has the insured provided certification for the implementation of an acceptable Drug Free Workplace Program?  Yes  No
- 15) Does the insured have a Workplace Safety Program in place?  Yes  No
- 16) Please indicate which of the following safety program elements are currently in effect:
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Driver Safety Program                                  | <input type="checkbox"/> Accident/Injury Investigations         | <input type="checkbox"/> Labor/Management Safety Committee   |
| <input type="checkbox"/> Safety Incentive Program                               | <input type="checkbox"/> Patient Handling/Transfer Training     | <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"/> Screening process for new hires        | <input type="checkbox"/> Functional testing of new hires     |
| <input type="checkbox"/> Management Involvement in safety (describe if checked) |   |  |
- Describe: \_\_\_\_\_
- 17) Has the insured provided certification of attendance to a state-sponsored cost containment seminar?  Yes  No

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- 18) Does the insured operate a licensed nursing home or provide medical & personnel care to the aged or infirm?  Yes  No  
If "yes", please describe: \_\_\_\_\_
- 19) Characterize the care and condition of the insured's premises. \_\_\_ Below Average; \_\_\_ Average; \_\_\_ Above Average  
Explain: \_\_\_\_\_
- 20) Characterize the insured's selection, training and supervision of employees. \_\_\_ Below Average; \_\_\_ Average; \_\_\_ Above Average  
Explain: \_\_\_\_\_
- 21) Characterize management's cooperation in providing resources to reduce frequency and severity of loss. \_\_\_ Below Average; \_\_\_ Average; \_\_\_ Above Average  
Explain: \_\_\_\_\_
- 22) Does the applicant have general liability and professional liability insurance in force? (If yes, state carrier)  Yes  No
- 23) Business Operations (check all that apply):

<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	<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"/> Job Assistance	<input type="checkbox"/> Outpatient Psychiatric Clinic	<input type="checkbox"/> Community Hospital
<input type="checkbox"/> Clinic	<input type="checkbox"/> Other (please specify):	

- 24) Please indicate where your employees perform their work:
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Private Homes/Apt. _____ % | <input type="checkbox"/> Clinics _____ %              | <input type="checkbox"/> Nursing Homes _____ %                              |
| <input type="checkbox"/> Doctor's Offices _____ %   | <input type="checkbox"/> Hospitals _____ %            | <input type="checkbox"/> Corporate Offices _____ %                          |
| <input type="checkbox"/> Clinic Setting _____ %     | <input type="checkbox"/> Community Residences _____ % | <input type="checkbox"/> Other Locations _____ %<br>(Please describe below) |
- Please describe: \_\_\_\_\_

25) Please enclose any available informational brochures describing operations, locations, services, etc.

26) Website Address: www. \_\_\_\_\_

Applicant Name (printed): \_\_\_\_\_ Signature: \_\_\_\_\_

Broker/Agent Name (printed): \_\_\_\_\_ Signature: \_\_\_\_\_

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