



All City Insurance

Workers' Compensation
Janitorial Supplemental Application

Applicant Name: Effective Date:
Federal ID No.: Web Address:
Phone Number: Email Address:
Producer currently writes applicant's work comp coverage?
Additional Coverages:
Preferred Pay Plan
Regulatory authority filing required?

A. PRIOR PAYROLL, PREMIUM, AND CARRIER INFO

Table with 4 columns: Term, Total Annual Payroll, Premium, Carrier. Rows include Current, 1st Prior, 2nd Prior, 3rd Prior, 4th Prior.

B. OPERATIONS

1. States of operations:
2. Does the applicant have any plans to begin operations in states not listed B.1. above?
3. Owners active in daily operations?
4. Hours of operations: From: To: 5. Number of shifts:
6. 24-hour exposure?
7. Year business established:
8. New venture or acquisition of an existing business?
9. Driving / delivery exposure?



All City Insurance

Company vehicles taken home? <input type="checkbox"/> Yes <input type="checkbox"/> No Employees use personal vehicles for company use? <input type="checkbox"/> Yes <input type="checkbox"/> No Vehicle/fleet maintenance program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> By Employees <input type="checkbox"/> By Outside Vendors Fleet safety program? <input type="checkbox"/> Yes <input type="checkbox"/> No Driver acceptability standards program? <input type="checkbox"/> Yes <input type="checkbox"/> No MVRs checked before or after hire? <input type="checkbox"/> Yes <input type="checkbox"/> No MVRs checked annually? <input type="checkbox"/> Yes <input type="checkbox"/> No Enrollment in DMV "Pull" Program? <input type="checkbox"/> Yes <input type="checkbox"/> No																																					
10. Heights of operations: (must equal 100%): <input type="checkbox"/> N/A <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; text-align: center;">% of Operations</td> <td style="width:20%; text-align: center;">Accessed Via</td> <td colspan="4"></td> </tr> <tr> <td style="text-align: center;">0 to 6 feet _____%</td> <td style="text-align: center;"><input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding</td> <td style="text-align: center;"><input type="checkbox"/> Cherry Picker / Boom</td> <td style="text-align: center;"><input type="checkbox"/> Scissor Lift</td> <td colspan="2" style="text-align: right;"><input type="checkbox"/> Other: _____</td> </tr> <tr> <td style="text-align: center;">7 to 15 feet _____%</td> <td style="text-align: center;"><input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding</td> <td style="text-align: center;"><input type="checkbox"/> Cherry Picker / Boom</td> <td style="text-align: center;"><input type="checkbox"/> Scissor Lift</td> <td colspan="2" style="text-align: right;"><input type="checkbox"/> Other: _____</td> </tr> <tr> <td style="text-align: center;">16 to 25 feet _____%</td> <td style="text-align: center;"><input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding</td> <td style="text-align: center;"><input type="checkbox"/> Cherry Picker / Boom</td> <td style="text-align: center;"><input type="checkbox"/> Scissor Lift</td> <td colspan="2" style="text-align: right;"><input type="checkbox"/> Other: _____</td> </tr> <tr> <td style="text-align: center;">26 to 35 feet _____%</td> <td style="text-align: center;"><input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding</td> <td style="text-align: center;"><input type="checkbox"/> Cherry Picker / Boom</td> <td style="text-align: center;"><input type="checkbox"/> Scissor Lift</td> <td colspan="2" style="text-align: right;"><input type="checkbox"/> Other: _____</td> </tr> <tr> <td style="text-align: center;">Over 35 feet _____%</td> <td style="text-align: center;"><input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding</td> <td style="text-align: center;"><input type="checkbox"/> Cherry Picker / Boom</td> <td style="text-align: center;"><input type="checkbox"/> Scissor Lift</td> <td colspan="2" style="text-align: right;"><input type="checkbox"/> Other: _____</td> </tr> </table> Maximum height of operations: _____ feet If scaffolding is used is it erected by employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are employees certified annually? <input type="checkbox"/> Yes <input type="checkbox"/> No Formal/documented fall protection program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, copy available? <input type="checkbox"/> Yes <input type="checkbox"/> No		% of Operations	Accessed Via					0 to 6 feet _____%	<input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding	<input type="checkbox"/> Cherry Picker / Boom	<input type="checkbox"/> Scissor Lift	<input type="checkbox"/> Other: _____		7 to 15 feet _____%	<input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding	<input type="checkbox"/> Cherry Picker / Boom	<input type="checkbox"/> Scissor Lift	<input type="checkbox"/> Other: _____		16 to 25 feet _____%	<input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding	<input type="checkbox"/> Cherry Picker / Boom	<input type="checkbox"/> Scissor Lift	<input type="checkbox"/> Other: _____		26 to 35 feet _____%	<input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding	<input type="checkbox"/> Cherry Picker / Boom	<input type="checkbox"/> Scissor Lift	<input type="checkbox"/> Other: _____		Over 35 feet _____%	<input type="checkbox"/> Ladders <input type="checkbox"/> Scaffolding	<input type="checkbox"/> Cherry Picker / Boom	<input type="checkbox"/> Scissor Lift	<input type="checkbox"/> Other: _____	
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13. Employees work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of work: _____																																					
14. Out of state, international, or overnight (within state) travel? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Why / Purpose: _____ Who will travel: _____ Where: _____ Duration: _____ Frequency: _____																																					
15. # employees live or work out of state: Live: _____ Work: _____																																					
16. Number of employees: Full Time: _____ Part Time: _____ Seasonal: _____ Volunteers: _____ If volunteers: Duties of volunteers: _____ Work comp coverage requested for volunteers? <input type="checkbox"/> Yes <input type="checkbox"/> No Accident, Health, or Disability Insurance provided to volunteers by applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No																																					
17. Last 12 months employee turnover: <input type="checkbox"/> <10% <input type="checkbox"/> 11-20% <input type="checkbox"/> 21-30% <input type="checkbox"/> >30% If >20%, why? _____																																					
18. Next 12 months employee count forecast: <input type="checkbox"/> Stable <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing																																					
19. Maximum # of employees at any one location: _____																																					
20. # W-2's issued last year: _____ Previous year: _____																																					
21. Employees paid: <input type="checkbox"/> Hourly <input type="checkbox"/> Flat Salary <input type="checkbox"/> Commission <input type="checkbox"/> Piece rate <input type="checkbox"/> Other: _____																																					
22. Employee to supervisor ratio: <input type="checkbox"/> <4:1 <input type="checkbox"/> 4:1 <input type="checkbox"/> 5:1 <input type="checkbox"/> 6:1 <input type="checkbox"/> 7:1 <input type="checkbox"/> >7:1																																					
23. % of union employees: _____ % of non-union employees? _____																																					
24. Day laborers or temporary / employee leasing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details: _____																																					
25. Average hourly wage for employees in governing class: \$_____/hour																																					
26. Average employee tenure with the company: _____ years																																					
27. Does applicant hire temporary labor in states where they are working on a temporary basis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A																																					
28. Are there any employees exempt from workers' compensation (e.g. casual labor, domestic servants, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No																																					
29. Does the applicant ever "borrow" a worker from another employer? <input type="checkbox"/> Yes <input type="checkbox"/> No																																					
30. Are there any employees from a PEO? <input type="checkbox"/> Yes <input type="checkbox"/> No																																					



All City Insurance

31. Interchange of labor? Yes No
 If yes: Another Business A Subsidiary Between Departments Other: _____

32. Subcontractors used? Yes No If yes, why? _____
 If yes, certificates of insurance kept on file? Yes No

33. Are independent contractors used? Yes No If yes, why: _____
 If yes, how paid: 1099's Other: _____

C. EMPLOYEE BENEFITS

1. Group medical plan provided? Yes No
 If yes: Provider name? _____ % of employees enrolled? _____ % paid by the employer? _____

2. Paid sick leave? Yes No

3. Paid vacation? Yes No

4. Retirement or pension plan? Yes No Employer contribute? Yes No

5. Specific medical provider used to treat injured employees? Yes No Clinic Physician Other: _____
 Distance to provider? _____ miles

6. Medical Provider Network (MPN)? Yes No MPN name? _____

7. CPR training provided? Yes No Number of certified employees? _____

D. HIRING AND EMPLOYEE PRACTICES

1. Written applications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reference checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic back testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Criminal background checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pathogenic (disease) testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-hire drug / substance abuse testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Formal job descriptions on file? <input type="checkbox"/> Yes <input type="checkbox"/> No
Post-accident drug/substance abuse testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Job-specific training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre or post hire employment physicals? <input type="checkbox"/> Yes <input type="checkbox"/> No	New employee orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Personnel files documented for pre-existing injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	

E. LOSS CONTROL AND SAFETY

1. Active injury & illness prevention program? Yes No

Written safety program? Yes No English Spanish Other: _____

Safety training / orientation? Yes No Formal/Documented Informal

Safety meetings? Yes No Frequency? _____

Active safety incentive program? Yes No Type of incentive? _____

Safety director or risk manager? Yes No Full time position? Yes No

Written accident reporting policy? Yes No

Written accident investigation procedure? Yes No

Supervisors accountable for injuries / accidents? Yes No

Return to work program? Yes No Salary continuation included? Yes No

Specific job training? Yes No

Forklift training? Yes No N/A

Machinery/equipment property guarded? Yes No N/A

Written lockout / tagout / blockout procedures? Yes No N/A

Respiratory program? Yes No N/A

Office ergonomic safety program? Yes No N/A

Personal protective safety equipment? Yes No N/A

If yes: Back Belts Boots Safety glasses Hearing Protection Respiratory Equipment
 Gloves Guard Rails Safety belts Ladder Tie Offs Full Body Harnesses
 Safety Nets Other: _____

2. OSHA citation in last year? Yes No If yes, please explain: _____

3. Loss control services performed in last year? Yes No
 If yes, required recommendations completed? Yes No



All City Insurance

F. OTHER CONSIDERATIONS

1. Bankruptcy (ever)? Yes No If yes, in last five years? Yes No

2. Years at current location: _____ 3. Age of occupied building: _____ years

4. Building / Premises: Owned Leased 5. Condition of premises: Excellent Very Good Good Average

6. Equipment condition: New Good Average N/A

7. Equipment operators trained and currently certified? Yes No N/A

8. Average claim reporting timeframe: _____ days

9. Any claim over \$25,000 in last four years? Yes No If yes, please provide the following information for each such claim:
 How did it occur? Is employee still working for the applicant?
 What was the injury? What corrective action has the applicant taken to prevent reoccurrences?

10. **This section must be completed by all applicants who are individuals, sole proprietorships, husband and wife, or partnerships (where the general partners are husband and wife).**
 Please list below any relatives residing in your household who are employees of your business and to whom your books and records show payments to such relatives:

Employed Relatives*			
Name	Relationship to You	Job Title or Duties	Estimated Annual Remuneration

Check here if there are no relatives residing in your household that are employed in your business.

***Relatives are defined as: spouse, child by birth or adoption, stepchild, grandchild, son-in-law, daughter-in-law, parent, step-parent, parent-in-law, grandparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, sister-in-law, uncle, aunt, nephew, or niece.**

Note: Per California Labor Code, as an employer you are required to include in your Workers' Compensation coverage all relatives residing in your household who are your employees. Any policy issued based on information provided in this application will exclude coverage for residing relatives if none are listed above.

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Arrowhead General Insurance Agency, Inc. must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

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Applicant Name _____

Date _____

Signature _____



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JANITORIAL CONTRACTORS

1. Check appropriate exposures in the following areas:

- Airports Fire/Flood/Restoration Hotels Museums Stores
- Apartments Government Industrial Plants Nursing Homes Other: _____
- Education Facilities Hospitals Medical Offices Office Buildings

2. Indicate % of services provided (must equal 100%):

- | | | |
|---|------------------------------------|---------------------------------|
| _____ Aircraft service and maintenance | _____ Fire / Flood restoration | _____ Landscaping |
| _____ Carpet cleaning | _____ Floor waxing and refinishing | _____ Mold Remediation |
| _____ Ceiling tile cleaning | _____ General cleaning* | _____ Parking Lot cleaning |
| _____ Chimney cleaning | _____ Gutter clean up | _____ Pest Control |
| _____ Crime Scene or Bio-Hazard clean up | _____ Hazardous Materials | _____ Pressure or steam washing |
| _____ Debris removal / Job site clean up | _____ Heating, A/C Ventillation | _____ Residential cleaning |
| _____ Elevator maintenance | _____ Hoods/Filters/Grease traps | _____ Roof clean up |
| _____ Exterior Window cleaning above ground level | _____ Industrial cleaning | _____ Snow removal |
| _____ Other: _____ | | |

*General cleaning includes, but not limited to vacuuming, dusting, wastebasket trash pick up, floor and rug cleaning, restroom clean-up

3. Employees work in pairs or more? Yes No No. of Employees on each crew? _____ Average _____ Maximum

4. How many locations does insured work at per shift on average? _____

5. What percentage of employees work at two (2) or more locations per night? _____ %

6. What percentage of operations take place between 10:00 p.m. and 6 a.m.? _____ %

7. Employees supervised? Yes No If yes, Direct Roving