

FUTURA FINANCIAL SERVICES

Workers Compensation Supplemental Application

Named Insured:			Date:
Insured's FEIN:			
	Contact Name	Phone Number	E-mail
Inspections:			
Premium Audit:			
Claims:			
Prior Payroll and Premium Information			
	Total Annual Payroll	Premium	
Expiring Policy Year:			
1st Prior Year:			
2nd Prior Year:			
3rd Prior Year:			
Operations			
Years in business _____	Hours of operation _____	# of shifts _____	
Is there a driving/delivery exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Radius of operations/travel _____	
If yes, what is frequency? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other		Is a PUC/DMV filing required? <input type="checkbox"/> PUC <input type="checkbox"/> DMV <input type="checkbox"/> N/A	
# of vehicles _____	# of drivers _____	Do employees use personal vehicles for company business? <input type="checkbox"/> Yes <input type="checkbox"/> No	
# of employees Full time _____	Part time _____	Seasonal _____	# of temporary positions held _____ Name of temp agency _____
# of employees per location #1 _____	#2 _____	#3 _____	#4 _____ #5 _____ #6 _____
Any volunteers? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many? _____	# of hours worked _____	List duties _____
# of W-2's issued last year _____	Previous year _____	Actual average hourly wage for employees in governing class \$ _____/hr	
Do you use a specific medical provider to treat injured employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		DMV Pull Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently participating in a MPN (Medical Provider Network)? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide the name of current MPN _____	
RTW Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, does it include salary continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the ownership of the applicable entity changed within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No		# of years at current location _____	
Any out of state or international travel? <input type="checkbox"/> Yes <input type="checkbox"/> No		# of employees travelling? _____	Frequency? _____ Duration of stay? _____
Does employer provide: Sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No		Vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hiring Practices/Employee Selection			
Written Applications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Reference Checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pre-hire drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No		Post accident drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MVR checks? <input type="checkbox"/> Yes <input type="checkbox"/> No		Formal job descriptions on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a formal written accident report? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is job specific training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does employer provide group health plans? <input type="checkbox"/> Yes <input type="checkbox"/> No		% paid by employer _____ % % participation: _____ %	
Employee Orientation Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is the orientation <input type="checkbox"/> Verbal only <input type="checkbox"/> Verbal and Documented	
Any interchange of labor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you performing pre-employment/post-hire physicals? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			

Safety Program

Are owners active in daily operations? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, are they excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have loss control services been performed in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are safety meetings conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	
Do employees receive safety training/orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is the training <input type="checkbox"/> Formal/Documented <input type="checkbox"/> Informal	
MSDS (Material Safety Data Sheets) available for all chemicals and products used? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Forklift training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are all equipment operators trained/certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is all machinery/equipment properly guarded? <input type="checkbox"/> Yes <input type="checkbox"/> No		Written lockout/tagout/blockout procedures in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Personal protection equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, strict enforcement of utilization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What types of PPE? _____		Respiratory program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the maximum height at which you will work? _____		Hearing conservation program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is used? <input type="checkbox"/> Ladder <input type="checkbox"/> Scaffolding <input type="checkbox"/> Scissor Lifts		If scaffolding used, does the insured build their own? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any manual lifting exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Max weight _____ lbs.	
Formal lifting policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Last OSHA inspection: _____ Have you ever been cited by OSHA? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Agriculture Questions

Number of acres _____		What type of crops? _____	
Do you grow table grapes? <input type="checkbox"/> Yes <input type="checkbox"/> No		Any employee transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is housing provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, number of employees housed _____	
Do you use a Farm Labor Contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No		% of harvesting done by FLC? _____% % of pesticide done by FLC? _____%	
How are employees paid? <input type="checkbox"/> Hour <input type="checkbox"/> Piece rate <input type="checkbox"/> Other _____ (describe)			
Harvesting is done <input type="checkbox"/> Mechanically <input type="checkbox"/> Manually		Machinery maintained <input type="checkbox"/> In-house <input type="checkbox"/> Outside vendor	
Number of seasonal employees that return each year? _____		Tractor roll over protection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you harvest for others? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, do you own equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Equipment maintained <input type="checkbox"/> In-house <input type="checkbox"/> Outside vendor			
Use of any ATV/ATC, 3 or 4 wheel? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Follow Cal OSHA Extreme Heat Safety Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Will you be involved in the H2A program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any crop dusting done by insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subcontracted out? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pesticide/Fertilizer application by employees? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Any training or certification? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Landscaping

Residential _____%		Commercial _____%		Municipal _____%	
Indicate % of operations:					
_____ % Off the ground tree trimming		_____ % Debris removal or clear cutting		_____ % Highway, roadway, or median work	
_____ % Boulder or tree removal		_____ % Hardscape work		_____ % Sprinkler installation / irrigation work	
_____ % Tree planting > 25 gallons		_____ % Use of tractors, loaders or similar equipment		_____ % Trenching	
_____ % Spraying of pesticides/fertilizers		_____ % Use of chippers, mulchers, cherry pickers, booms, and similar equipment			

Contractors

License number: _____ Years of experience in trade: _____ % of work subcontracted out: _____% Type: _____

If subs used, does insured: Check annually? Yes No Directly supervise subs? Yes No

Indicate % of work: _____ % New Construction _____ % Remoderling _____ % Service / Repair
 _____ % Single Custom Homes _____ % Apts/Condos/Tract Homes _____ % Commercial
 _____ % Interior _____ % Exterior If exterior work done, what is max height? _____

Height exposure / Indicated % worked: <12' _____% 12' to 24' _____% 24' to 40' _____% >40' _____%

What is used? _____ Ladder _____ Scaffolding _____ Scissor Lifts _____ NA Does Insured build own scaffolding Yes No

Fall protection program in place Yes No Guardrails Yes No Safety belt or full body harness Yes No
 Ladder tie-offs Yes No Ladder / Scaffold training Yes No Safety net Yes No

Use of cranes or booms? Yes No Any work below grade? Yes No Max depth in feet _____ % of total work _____%

Any work involving asbestos, hazardous product abatement, chemical / petroleum products, underground tanks, USL&H or pipe replacement? Yes No

If yes, please explain: _____

Any welding? Yes No Involved in any OCIP or Wrap Up projects? Yes No

Indicate % of work conducted: Blasting _____% Drilling _____% Light pole work _____% Demolition _____% Tunneling _____%
 Grading _____% Wrecking _____% Gas Mains _____% Crane Work _____% Asbestos _____% Highway _____%
 Roofing _____% Excavation _____% Sewer _____% Ext. Framing _____% Bridge Work _____%
 Concrete tilt-up _____% Multi-story bldgs _____% Scaffold set up _____% Structural Steel _____%

Automotive Services

Any towing services? Yes No If yes, any contract towing? Yes No Any fueling operations? Yes No

Any road repair assistance? Yes No If yes, 24 hour exposure? Yes No Any security / surveillance cameras? Yes No

Any test driving of vehicles? Yes No Mile radius > 5 miles? Yes No Any work performed on trucks over 1 ton? Yes No

Any group transportation / shuttle of employees? Yes No If yes, how many ee's at one time? _____ Any split rim work performed? Yes No

Are employees ASE trained and certified? Yes No If yes, how many employees? _____ Number of service bays? _____

Is tire repair or installation performed? Yes No Any tire recapping? Yes No

Is there a car wash on the premises? Yes No If yes: Full Service Automated

Are spray booths mechanically ventilated & Air Quality District Certified? Yes No N/A

Personal protective equipment provided and usage enforces? Yes No Is there a formal written respirator program? Yes No

Are paints, cleaning agents, and flammable fluids properly stored? Yes No Is there an eye wash and body wash facility? Yes No

Are routine scheduled inspections & maintenance on shop equipment performed? Yes No