STATE COMPENSATION INSURANCE FUND

SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

"Call to set a :15min phone review appointment"

(442)500-2011

Barrie D. Elliott Insurance Agency, Inc.
P.O. Box 4061
Carlsbad, CA 92018-4061
(442)500-2011
Email: Barrie@Here2Insure.com

Section 1 - Trade Name (i.e., DBA)

Current:
Prior (if applicable):

Section 2 - Business Ownership

Legal Name:

Legal Entity (check one):

☐	1	Individual (If married, check Husband & Wife)	☐	N	Non-Profit Organization	☐	C	Conservatorship
☐	2	Husband & Wife (Both names required in Legal Name.)	☐	3	Joint Venture	☐	E	Estate
☐	4	General Partnership	☐	8	Public Agency	☐	T	Trust
☐	L	Limited Partnership	☐	P	Incorporated Public Agency	☐	6	Association
☐	5	Corporation	☐	9	Labor Union	☐	J	Joint Employer
☐	M	Non-Profit Corporation	☐	U	Incorporated Labor Union	☐	A	Common Ownership
						☐	7	Other:

Section 3 - Licenses

2101	Farm Labor Contractor License:
3405	Contractor's State License Board No./Type/Expiration Date:
3408	PUC/ICC License Number:
3409	Other License Numbers required to do business in CA (please specify):

Section 4 - Additional Business Information

2075	Phones: Bus. ( ) - Home ( ) -
2075	FAX Number: ( ) -
2075	E-Mail Address:
2099	State Employer Identification Number:

Section 5 - Social Security Number(s)

2096

Please provide the Social Security Number(s)* for individual owner, husband, wife, corporate officers, or general partners. Attach a separate page if necessary.

(1) Name: _____ *Social Security Number: ___ - ___ - ____

(2) Name: _____ *Social Security Number: ___ - ___ - ____

(3) Name: _____ *Social Security Number: ___ - ___ - ____

(4) Name: _____ *Social Security Number: ___ - ___ - ____

***DISCLOSURE STATEMENT**

Providing Social Security Numbers is voluntary. If the principals do not wish to provide Social Security Numbers, other acceptable identification shall include: 1) Federal Employer Identification Number (FEIN), 2) State Employer Identification Number (SEIN), 3) Contractor's License or 4) any applicable business license pertinent to the trade or business.

Section 6 - General Information

Do any of the following pertain to the operations of this risk? **Please explain all "yes" answers to questions 1-10 in the "Remarks" section on page 2.**	Yes	No		Yes	No
1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press)?	☐	☐	8. Have any location/operations for which coverage is not requested?	☐	☐
2. Employ any relatives?	☐	☐	9. Have any operations outside of California?	☐	☐
3. Employ any minors (under age 18)?	☐	☐	10. Perform any asbestos removal?	☐	☐
4. Make any cash payments to employees or subcontractors?	☐	☐	11. Member of any trade or business association?	☐	☐
5. Provide meals or lodging in lieu of wages?	☐	☐	Please indicate: _____		
6. Pay any employees by the piece?	☐	☐			
7. Have any work at a maritime or offshore facility?	☐	☐			

Section 7 - Has the business or any principal of the business declared bankruptcy in the last seven years? ☐ **Yes** ☐ **No, skip to Section 8**

Name of Principal:

3105 Chapter of bankruptcy filed (check as applicable): ☐ 7 ☐ 11 ☐ 13 ☐ Other:

Date filed: | Case Number: | Status: ☐ pending ☐ dismissed ☐ discharged

Court where case was filed (Please provide us with a filed, stamped copy of the "Petition for Relief".):

Section 8 - Was this operation all or part of an existing business that was purchased or acquired? ☐ **Yes** ☐ **No, skip to Section 9**

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What percentage of the business was acquired?:	Date ownership changed:
Prior business owner's name and address: Name: _____ Address: _____ Name of Business: _____	
Is the prior owner(s) related to the new owner(s)? ☐ No ☐ Yes, Relationship:	
Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? ☐ No ☐ Yes, please explain:	
Were more than 50% of the current employees hired since the acquisition? ☐ Yes ☐ No	Are those new employees earning more than 50% of the payroll? ☐ Yes ☐ No

Section 9 - Management Practices

Please indicate if you offer: Employee Assistance Program ☐	Paid Vacations ☐ Paid Sick Leave ☐
Do you have a minimum of 2 employees? ☐ No ☐ Yes	
If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) ☐ No ☐ Yes	
If yes, do you pay at least 50% of the Health Insurance premium? ☐ No ☐ Yes, Name of Health Insurance Carrier:	
Please check off the hiring practices implemented by your company: Job Descriptions ☐	Pre-placement Medical Screening ☐
Pre-placement Drug Testing ☐ Drug-free Workplace ☐	Pre-employment Reference Check ☐ Union Employees ☐
Do you have an injury and illness Prevention Program? ☐ No ☐ Yes	
Do you have a written early return-to-work program for employees injured on the job? ☐ No ☐ Yes	
Do you document: Employee Training ☐	Facility Inspections ☐
Describe your housekeeping: Good ☐ Fair ☐ Poor ☐	Describe the condition of your equipment: Good ☐ Fair ☐ Poor ☐
Have you received any OSHA citations within the past year? ☐ No ☐ Yes (Please explain in "Remarks.")	
Does the business provide temporary employees? ☐ No ☐ Yes (Please explain in "Remarks.")	

Section 10 - Remarks (Attach a separate sheet if necessary.)

Section 11 - Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030	
BROKER ACCESS NUMBER	FIRM NAME
ADDRESS	CITY
( ) -	( ) -
PHONE NUMBER	FAX NUMBER

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SIGNATURE

To be completed by broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Name: _____ Please print	Title: _____ Please print
Signature: _____ *(FAXed applications must be followed up with original document signature.)*	Date: _____

Privacy & Confidentiality Notice: The Information Practices Act of 1977 (Civil Code Section 1798.17) and Federal Privacy Act requires that this notice be provided when collecting personal information from individuals.

State Fund uses information on this form for the purposes of identification and document processing. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in an inability to process your request.

You have the right to access the personal information collected about you in order to have it corrected, amended or deleted where it is inaccurate or inappropriate for the specified purposes of processing. You may contact the State Fund's Privacy Office via email at privacyoffice@scif.com or by phone (888) 724-3237 to process your request.