



Named Insured:		Web Address:	
Insured's FEIN:			
CONTACT NAME		PHONE NUMBER	
Inspections:			
Premium Audit:			
Claims:			
Prior Payroll and Premium Information			
	Total Annual Payroll	Premium \$	
Current Year:			
Prior Year:			
Prior Year:			
Prior Year:			
Prior Year:			
OPERATIONS AND BENEFITS			
Broker controlled account? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you a member of the Chamber of Commerce? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide County & membership number:	
Please provide a detailed description of the operation:			
Years in business?		Hours of operation:	
No. of shifts:_____ Does the applicant allow employees to work more than three consecutive 12-hour shifts? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is there a driving or delivery exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Radius of operations/travel: <input type="checkbox"/> <10 miles <input type="checkbox"/> 11-50 <input type="checkbox"/> 50-100 <input type="checkbox"/> 100+	
If yes, what is the frequency? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other:		Any group transportation of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a PUC/DMV filing required? <input type="checkbox"/> PUC <input type="checkbox"/> DMV <input type="checkbox"/> N/A		If yes, how provided? <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus	
Are vehicles company owned? <input type="checkbox"/> Yes <input type="checkbox"/> No		No. of employees transported per vehicle	
If yes, types of vehicles:		No. of vehicles used to transport:	
If yes, are vehicles taken home: <input type="checkbox"/> Yes <input type="checkbox"/> No		Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
No. of vehicles:	No. of drivers:	Is insured enrolled in DMV Pull program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vehicle/fleet maintenance program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are driver acceptability standards in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who does the servicing?		If yes, provide details:	
Outside vendor: <input type="checkbox"/>			
In-house mechanics: <input type="checkbox"/>			
Other: <input type="checkbox"/>			
Does insured have and enforce the following policies for drivers:			
Alcohol/drug use: <input type="checkbox"/> Yes <input type="checkbox"/> No Seat belt use: <input type="checkbox"/> Yes <input type="checkbox"/> No Distracted driving: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Any work-related injuries as a result of a prior motor vehicle accident within the past four years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details, including fault of accident and if subrogation was pursued:			
Do employees use personal vehicles for company business? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Out-of-state, international or overnight (within state) travel? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do any employees work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide details:		No. of employees who live/work out of state: _____Live _____Work	
Why/purpose?			
Who will travel?	Where?	Duration?	Frequency?
No. of employees: (verify no. is consistent w/ no. on ACORD application)	Full:	Part:	Seasonal:
No. of employees per location:	1.	2.	3.
			4.
Use a separate page if needed.			
No. of W-2s issued: Last Year: _____ Previous Year: _____		Paid sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Paid vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How are employees paid:	Hourly: <input type="checkbox"/>	Piece rate: <input type="checkbox"/>	Commission: <input type="checkbox"/> Flat Salary: <input type="checkbox"/> Other: <input type="checkbox"/>
Any day laborers or temporary/employee leasing? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide details on separate page.	

% of union employees:	% of non-union:	Actual avg. hourly wage for employees in governing class: \$_____
Retirement/pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does employer contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group medical provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If group medical is provided, who is the healthcare provider?	
% of employees enrolled:	% paid by employer:	
Do you use a specific medical provider to treat injured employees? <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:		
CPR training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	RTW program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
No. of employees certified?	Does it include salary continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the ownership of the applicable entity changed within the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please provide details:		
HIRING PRACTICES - EMPLOYEE SELECTION - CLAIMS		
Written application? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-hire drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reference checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Post-accident drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pre/post employment physicals? <input type="checkbox"/> Yes <input type="checkbox"/> No	MVR checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Orthopedic back testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Audio hearing tests? <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	
Are personnel files documented for pre-existing injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there set procedures for reporting claims? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Average claim reporting time frame:	Any interchange of labor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is job specific training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: <input type="checkbox"/> Another business <input type="checkbox"/> Subsidiary <input type="checkbox"/> Between departments <input type="checkbox"/> Other:	
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?	
Employee to Supervisor ratio: <input type="checkbox"/> Better than 4-1 <input type="checkbox"/> 5-1 <input type="checkbox"/> 6-1 <input type="checkbox"/> 7-1 <input type="checkbox"/> >7-1		
Subcontractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what purpose?	
If yes, are certificates of insurance obtained and kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Independent contractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what purpose?	
If yes, how are they paid? <input type="checkbox"/> 1099s? <input type="checkbox"/> Other? Please explain.		
SAFETY PROGRAM AND ORGANIZATION - WORK PREMISES AND ENVIRONMENT		
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	
Active injury & illness prevention program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has loss control services been performed in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Active safety incentive program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Cal/OSHA visited/cited your business in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, does it encompass all employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide explanation on separate page.	
What type of incentive?	Are safety meetings conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do employees receive safety training/orientation? <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 <input type="checkbox"/> Other	
If yes, is the training: <input type="checkbox"/> Formal / Documented <input type="checkbox"/> Informal		
Do you have a safety director or risk manager? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and title:	
If yes, is the position full time or an additional responsibility of another employee?		
MSDS (Material Safety Data Sheets) available for all chemicals and products used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Any material handling exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:	
Any lifting exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Forklift training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
If yes, <input type="checkbox"/> <25 lbs. <input type="checkbox"/> 25-40 <input type="checkbox"/> 40+	If yes, annual certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If 40+, manual lifting or with assistance? Please explain:		
Is all machinery/equipment properly guarded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Any use of Baler equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Written lockout/tagout/blockout procedures in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Condition of equipment? <input type="checkbox"/> New <input type="checkbox"/> Good <input type="checkbox"/> Average	
Respiratory program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of equipment? <input type="checkbox"/> 0-5 years <input type="checkbox"/> 5-10 <input type="checkbox"/> 10-20 <input type="checkbox"/> 20+	
What is the maximum height at which you will work? _____ feet	Please see Contractors Section for further elaboration.	
What is used? <input type="checkbox"/> Ladder <input type="checkbox"/> Scaffolding <input type="checkbox"/> Scissor lifts <input type="checkbox"/> N/A	If scaffolding used, does the insured build their own? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If insured builds own scaffolding, provide % of annual operations involving scaffold setup and teardown compared to total operations. _____ %		
Written Fall Protection Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please see Contractors Section for further elaboration.	
Are all equipment operators trained/ certified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Personal protection equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Is the building/premises: <input type="checkbox"/> Owned <input type="checkbox"/> Leased?	If yes, strict enforcement of utilization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Condition of premises? <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Average	What types of PPE?	
No. of years at current location?	Age of building occupied? _____ years	

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.

Signature of Applicant:	Date:
-------------------------	-------

HEALTH AND HUMAN SERVICES

Is applicant a licensed facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
--	-------------------------

Is operation accredited by CARF (Commission on Accreditation Rehabilitation Facility)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
--

Is group transportation provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number of company vehicles:	Number of personal vehicles:
--	-------------------------------------	------------------------------

Percentage of group transportation subcontracted? _____ % <input type="checkbox"/> N/A
--

Any off-site activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details:
---	--------------------------

Does applicant offer "live-in" employees at client's residence/premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what percentage?
---	--------------------------

Does applicant employ relatives of their clients? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

If yes, provide number of family related employees employed:
--

Provide the typical relationship of employees to client (i.e. daughter, son, brother, sister, mother, father, etc.):
--

Are relative employees held to the same hiring practices and training standards as all other employees? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Are remuneration/compensation packages the same for "relative employees" as for "non-relative employees"? <input type="checkbox"/> Yes <input type="checkbox"/> No
--

If no, provide details:

Are certificates of insurance obtained from all subcontracted operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average # of certificates collected annually? _____
--	---

Does risk have a written Blood Borne Pathogen Program? <input type="checkbox"/> Yes <input type="checkbox"/> No

Does this risk treat for HIV and/or AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Does risk have patient/resident handling/lifting equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does risk have written patient/resident handling protocols? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Does risk provide ongoing In-Service Training? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often?
---	--------------------

Provide percentage of residents/patients:	Ambulatory:	Non-Ambulatory:
---	-------------	-----------------

Does risk provide food service? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide details:
--	---------------------------------

Does risk have volunteers? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
--

If yes, provide details (# of volunteers, duties performed, etc.):
--

Indicate percentage of operations in each of the following categories or mark not applicable - <input type="checkbox"/> N/A

Abortion Clinic:	Acupuncture/Acupressure:	Blood banks/Donor Clinic:	Drug/alcohol Treatment Clinic:
------------------	--------------------------	---------------------------	--------------------------------

Family Practice:	Industrial Clinic:	Med Lab/testing:	Specialist:
------------------	--------------------	------------------	-------------

Mobile Operation:	Urgent Care Clinic:	Walk-in Clinic:	Weight Control Clinic:
-------------------	---------------------	-----------------	------------------------

Other:

Indicate percentage of operations in each of the following categories or mark not applicable - <input type="checkbox"/> N/A

Physicians/MD:	PhD:	Psychiatrist:	Psychologist:
----------------	------	---------------	---------------

Physicians Asst.:	Nurse Practitioner:	Registered Nurse:	Licensed Voc. Nurse:
-------------------	---------------------	-------------------	----------------------

Cert. Nurses Asst.:	Social Worker:	Counselor:	Dietary:
---------------------	----------------	------------	----------

Dentists/ Surgeons:	Registered Dental Asst.:	Dental Hygienist:	Chiropractor:
---------------------	--------------------------	-------------------	---------------

Physical Therapist:	Physiotherapist:	Occupational Therapist:	Administrative:
---------------------	------------------	-------------------------	-----------------

Does insured require employees to take specific health care-related classroom or online classes which would give them a certificate or certification after passing? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What percentage of total employees?			
If yes, provide details regarding the type of certification:			
If organization is a day care center or provides day care operations indicate the %: Children age up to 1yr:_____ 1-3yrs_____ 3-5yrs_____			
Maximum enrollment:		Number of currently enrolled children:	
Provide ratio of child-care staff to children: <input type="checkbox"/> 1 to 2 <input type="checkbox"/> 1 to 3 <input type="checkbox"/> 1 to 4 <input type="checkbox"/> Other, explain:			
Is the operation based out of a home residence? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If operation provides veterinary services please provide %: Domestic/Household pets_____% Farm animals_____% Exotic/Wild_____%			
Provide details:			
Provide percentage of the following:		Grooming: _____ %	Kennel: _____ %
			Boarding: _____ %
Any field or off-site services provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide details:	