ARROWHEAD
Workers' Compensation

Supplemental Application

To be completed with ACORD 130 Application

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? ☐Yes ☐No

Does applicant currently use a PEO or payroll service? ☐Yes ☐No | If yes, provide name of organization used:

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? ☐Yes ☐No

Is there a driving or delivery exposure? ☐Yes ☐No | Radius of operations/travel: ☐<10 miles ☐11-50 ☐50-100 ☐100+

If yes, what is the frequency? ☐Daily ☐Weekly ☐Other: | Any group transportation of employees? ☐Yes ☐No

Is a PUC/DMV filing required? ☐PUC ☐DMV ☐N/A | If yes, how provided? ☐Car ☐Truck ☐Van ☐Bus

Are vehicles company owned? ☐Yes ☐No | No. of employees transported per vehicle:

If yes, types of vehicles: | No. of vehicles used to transport:

If yes, are vehicles taken home: ☐Yes ☐No | Frequency: ☐Daily ☐Weekly ☐Monthly

No. of vehicles: | No. of drivers: | Is insured enrolled in DMV Pull program? ☐Yes ☐No

Vehicle/fleet maintenance program? ☐Yes ☐No | Are driver acceptability standards in place? ☐Yes ☐No
If yes, provide details:

If yes, who does the servicing?
Outside vendor: ☐
In-house mechanics: ☐
Other: ☐

Does insured have and enforce the following policies for drivers:
Alcohol/drug use: ☐Yes ☐No Seat belt use: ☐Yes ☐No Distracted driving: ☐Yes ☐No

Any work-related injuries as a result of a prior motor vehicle accident within the past four years? ☐Yes ☐No

If yes, please provide details, including fault of accident and if subrogation was pursued:

Do employees use personal vehicles for company business? ☐Yes ☐No

Do any employees work from home? ☐Yes ☐No | No. of employees who live/work out of state: | Live: | Work:

Any out-of-state, international or overnight (within state) travel? ☐Yes ☐No | If yes, provide details:

Why/purpose?

Who will travel?	Where?	Duration?	Frequency?

No. of employees: (verify number is consistent w/ number on ACORD application)	Full:	Part:	Seasonal:	Volunteers:
No. of employees per location:	1.	2.	3.	4.	Use a separate page if needed.

Average annual employee turnover:______________________% | No. of W-2s issued: Last Year: | Previous Year:

How are employees paid? Hourly: ☐ Piece rate: ☐ Commission: ☐ Flat Salary: ☐ Other: ☐

Any interchange of labor? ☐Yes ☐No If yes, please explain: ☐ Another business ☐Subsidiary ☐Between departments ☐Other

Any day laborers or temporary/employee leasing? ☐Yes ☐No		
% of union employees:	Average hourly wage for employees in governing class: $	
%of non-union:	Retirement/pension plan? ☐Yes ☐No	Does employer contribute? ☐Yes ☐No
Group medical provided? ☐Yes ☐No	If group medical is provided, who is the healthcare provider?	
% of employees enrolled:	% paid by employer:	
Do you have a wellness program (ie encourages and promotes employee health programs) in place? ☐Yes ☐No		
Do you provide paid sick leave? ☐Yes ☐No	Paid vacation? ☐Yes ☐No	
Do you use a specific medical provider to treat injured employees? ☐Yes ☐No		
Are you currently participating in a MPN (Medical Provider Network)? ☐Yes ☐No		
If yes, please provide the name of current MPN:		
CPR training provided? ☐Yes ☐No	Return to Work Program (RTW) in place? ☐Yes ☐No	
No. of employees certified?	Does it include salary continuation? ☐Yes ☐No	
Has the ownership of the applicable entity changed within the past five years? ☐Yes ☐No		
If yes, please provide details:		

HIRING PRACTICES - EMPLOYEE SELECTION - CLAIMS

Written application? ☐Yes ☐No	Pre-hire drug testing? ☐Yes ☐No
Reference checks? ☐Yes ☐No	Post-accident drug testing? ☐Yes ☐No
Background checks? ☐Yes ☐No	MVR checks? ☐Yes ☐No
Pre/post employment physicals? ☐Yes ☐No	Audio hearing tests? ☐Yes ☐No
Orthopedic back testing? ☐Yes ☐No	Do you have a formal written accident report? ☐Yes ☐No
Formal job descriptions on file? ☐Yes ☐No	Are there set procedures for reporting claims? ☐Yes ☐No
Average claim reporting time frame:	Are supervisors held accountable for injuries/accidents? ☐Yes ☐No
Is job specific training provided? ☐Yes ☐No	
Employee Orientation Program? ☐Yes ☐No	If yes, is the orientation: ☐ Verbal only? ☐ Verbal and Documented?
Employee to Supervisor ratio: ☐Better than 4-1 ☐ 5-1 ☐6-1 ☐7-1 ☐ >7-1	
Subcontractors used? ☐Yes ☐No	If yes, for what purpose?
If yes, are certificates of insurance obtained and kept on file? ☐Yes ☐No	
Independent contractors used? ☐Yes ☐No	If yes, for what purpose?
If yes, how are they paid? ☐1099s? ☐ Other? Please explain.	

SAFETY PROGRAM AND ORGANIZATION - WORK PREMISES AND ENVIRONMENT

Are owners active in daily operations? ☐Yes ☐No	If yes, are they excluded from coverage? ☐Yes ☐No
Active injury & illness prevention program? ☐Yes ☐No	Heat illness prevention program? ☐Yes ☐No
Active safety incentive program? ☐Yes ☐No	Has loss control services been performed in the last year? ☐Yes ☐No
If yes, does it encompass all employees? ☐Yes ☐No	Has Cal/OSHA visited/cited your business in the last year? ☐Yes ☐No
What type of incentive?	If yes, please provide explanation on separate page.
Do employees receive safety training/orientation? ☐Yes ☐No	Are safety meetings conducted? ☐Yes ☐No
If yes, is the training: ☐ Formal / Documented ☐ Informal	If yes, how often? ☐Daily ☐Weekly ☐Monthly ☐Quarterly ☐Other
Do you have a safety director or risk manager? ☐Yes ☐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? ☐Yes ☐No ☐N/A	
Any material handling exposures? ☐Yes ☐No	If yes, please explain:
Any lifting exposures? ☐Yes ☐No	Forklift training provided? ☐Yes ☐No ☐N/A
If yes, ☐ <25 lbs. ☐25-40 ☐ 40+	If yes, annual certification? ☐Yes ☐No
If 40+, manual lifting or with assistance? Explain:	
Is all machinery/equipment properly guarded? ☐Yes ☐No ☐N/A	Any use of Baler equipment? ☐Yes ☐No
Written lockout/tagout/blockout procedures in place? ☐Yes ☐No ☐N/A	Condition of equipment? ☐New ☐Good ☐Average
Respiratory program in place? ☐Yes ☐No	Age of equipment? ☐ 0-5 years ☐ 5-10 ☐ 10-20 ☐ 20+
What is the maximum height in feet you will work?	Please see Contractors Section for further elaboration.
What is used? ☐ Ladder ☐ Scaffolding ☐ Scissor lifts ☐ N/A	If scaffolding used, does the insured build their own? ☐Yes ☐No
If insured builds own scaffolding, provide % of annual operations involving scaffold setup and teardown compared to total operations:	
Written Fall Protection Program? ☐Yes ☐No	Please see Contractors Section for further elaboration.
Are all equipment operators trained/ certified? ☐Yes ☐No ☐N/A	Personal protection equipment provided? ☐Yes ☐No ☐N/A
Is the building/premises: ☐ Owned ☐ Leased?	If yes, strict enforcement of utilization? ☐Yes ☐No
Condition of premises? ☐ Excellent ☐ Very good ☐ Average	What types of PPE?
No. of years at current location?	Number of years of building occupied?

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:

RESTAURANTS							
Entertainment provided? ☐Yes ☐No				Fast food? ☐Yes ☐No			
Liquor sales as percentage of total receipts: ______%				Bar or separate lounge area? ☐Yes ☐No			
Does the applicant have an established protocol practiced by employees regarding no over-serving of liquor? ☐Yes ☐No							
If yes, provide brief description:							
Any catering? ☐Yes ☐No If yes, radius of operations:_______mi.				Percent of catering exposure: ______%			
Number of:	Hosts:	Waitstaff:	Bartenders:	Valet:	Busboys:	Cooks:	Bouncers:
Any delivery? ☐Yes ☐No		Delivery hours:________to_______		If yes, radius of operations: _______mi.		Percent of exposure: ______%	
Any two-wheeled delivery exposure? ☐Yes ☐No			If yes, provide details:				
Average price of entrée? ☐ <$5 ☐ $5-$15 ☐ $15+							
Servicing, cleaning of hoods/filters/grease traps or related systems provided by: ☐ Outside vendor ☐ Employees							
Does insured have slip-resistant flooring or matting on premises? ☐Yes ☐No							
Are employees required to wear slip-resistant shoes? ☐Yes ☐No							
Any robbery, burglary or assaults within the past four years? ☐Yes ☐No							
If yes, provide details:							