Workers Compensation Supplemental Application

Submitting Producer:_____ Contact Person:_____ Phone No.: _____

Insured Name: _____ Effective Date: _____

Description of Operations: Detailed description including breakdown of employees by basic job duties, products or process, primary customers.

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Historical Total Payrolls:

2006	2005	2004	2003	2002

Historical Premiums Paid:

2006	2005	2004	2003	2002

1. Current number of permanent employees _____ Number of full time employees _____ Number of part time employees _____
   Number of Governing or Primary Class employees (if known)_____ Number of W - 2's filed for latest reporting year _____
   Average employee tenure _____ Average age range _____ Average experience level _____
2. Wage level for employees in primary operating class or governing code $_____ per hour
3. Employee benefits: Union Affiliation yes/no_____ Vacation yes/no _____ Paid sick leave yes/no _____
   Disability yes/no _____ Retirement (401K Plan) yes/no _____
   Health Insurance yes/no _____ employee participation _____% paid by employer _____%

Risk Management

1. Hiring & Screening Practices.
   References checked yes/no _____ Pre-employment physicals yes/no _____ Drug testing yes/no _____
2. Formal Return to Modified Work or Light Duty program yes/no _____
   What percentage of employees have light duty available to them _____
   Define Types of light duty positions available: _____
3. Loss control incentive plan yes/no _____ Sr. Management commitment & supervisor accountability for results yes/no _____
4. Written Safety Program yes/no _____ Enforced yes/no _____ Accident Investigations yes/no _____
   Safety Meetings yes/no __ Frequency _____ MVR's checked yes/no _____
5. Does company utilize specific medical clinic for work related injuries? yes /no _____
   Name of Clinic: _____

6. Provide a explanation of any losses over $25,000 and actions taken by insured to prevent re-occurrence