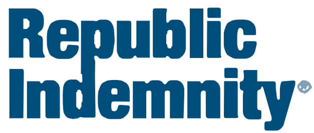

HOME HEALTH CARE
SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

Application/Policy #:_________________

Insured Name: ____Federal ID #: ________________________________
Effective Date: __________ Web Site: ________________________ Insurance Email: ______________________________
Agency: ____ Contact: ____

Payroll Data - Provide historical payroll data by class (for current and prior 4 years), or submit final audit invoices if available. Applicable only to policy years not insured by Republic Indemnity.

Class:	___________	___________	___________	___________	___________
YEAR					
Current	___________	___________	___________	___________	___________
1st Prior Yr	___________	___________	___________	___________	___________
2nd Prior Yr	___________	___________	___________	___________	___________
3rd Prior Yr	___________	___________	___________	___________	___________
4th Prior Yr	___________	___________	___________	___________	___________

Loss Experience

If the insured has not been insured by Republic Indemnity for the latest 3-year term, please attach **currently valued loss runs** for any of those three years insured elsewhere **and most current experience modification worksheet** if available.

Operational Information - Home Health Care

1. Provide the number of workers in each category.

   Registered nurses (RN, LPN) ______ Nursing assistants (CNA) ______ Personal care aides ______
   Home health aides _______ Companions ______ Other home care workers *______
   *Description of duties for other workers____
   ____

2. Average length of shifts in hours________ Average/typical number of patients per shift _________

3. Are there any live-in caregivers (uses a bed on the patient's premises)? Yes No If yes, how many? _______
   Do any family members provide paid care? Yes No If yes, how many? _______

4. Percent of non-ambulatory patients __________

5. Does the insured screen patients before providing services? Yes No

   If yes, what are their criteria for acceptance/rejection?____
____

6. Are nursing care providers required to lift patients (as opposed to repositioning or transferring)? Yes No

7. Is there a combative patient handling program, i.e. de-escalation techniques and safe restraint methods? Yes No

8. What are the procedures when working with larger patients?
   ____

General Information

1. Current number of permanent employees for each location:
   Employees providing medical, nursing or personal care to residents: ____________________
   Food service employees: ____________________
   All other employees, salespersons and drivers: ____________________

2. Number of W2's filed for latest reporting year____________________

3. Number of employees: Increasing ________ Decreasing ________ Stable ________

4. Number of part time employees ____________ Number of full time employees ________________

5. Mean wage: For mainstream employees in production operations or services offered $__________/hr.
   For administrative staff (e.g. clerical, sales) $__________/hr.

6. Union Non – Union % of employees participating______________

7. **How many independent contractors are used? __________**
   How many 1099 forms are issued to individuals? __________
   How many 1099 forms are issued to companies/organizations? __________
   If there are independent contractors, what kind of work do they perform?____________________
   Are independent contractors covered under a statutory Workers' Compensation Insurance policy and do they provide Certificates of Insurance? Yes No

8. Group Medical provided: Yes No Name of Group Medical Provider ____________________
   % of employees participating __________ % of employer contribution __________
   Paid Vacation: Yes No Paid Sick Leave: Yes No 401K or Pension: Yes No

9. Safety Program: Yes No
   Safety meetings held for all employees: Yes No
   Personal protective safety equipment provided: Yes No
   Accident investigation program in place: Yes No

10. Hiring Practices
    Application: Yes No
    Check References: Yes No

11. Pre-employment physical Yes No

12. Drug Screening Program/Random Drug Testing Yes No

13. Background Checks Yes No

14. Does insured offer modified work: Yes No
    If yes, provide details____

15. Vehicle Exposure: Yes No Radius of Operations ____________________
    #Vehicles_______ (comm'l) _______ (private passenger) Types of vehicles: Bus Van Car
    Details of use, including specifics as to delivery exposures, or group transportation exposures if applicable ______________
    ____
    Number of employees regularly driving: *__________
    *We define regular as over 10% of all production employees time in the aggregate being spent off-premises.
    Frequency of off-premises activity: Daily Less than Daily
    What are the average and maximum number of covered employees that travel together in the same vehicle: __________________
    ____
    How often do the maximum number of covered employees travel together in the same vehicle: ____________________
    MVR's checked Yes No If yes, please provide details as to procedures in place ____________________
    ____
    Is there a disciplinary/termination rule in place based on driving record? Yes No If yes, describe how this is implemented
    ____

16. Is there any out-of-state travel? Yes No
    Where do they travel? ________________________
    If yes, who travels? ______________________________________
    How long do they travel for? ______________________________

17. Does the applicant own, operate or lease aircraft: Yes No
    *If yes, provide details*____

18. Are any of the insured's operations located within a Federal or State government owned building that is over 35% occupied by governmental offices or National Landmarks? Yes No
    *If yes, provide details*____

Application/Policy #____________________

Location (s) – Please complete for all locations of business operations:

	# Employees assigned to location (including those who work off premises) Full-time	Part-time	# of Shifts	Maximum number of employees on premises at one time	# of Stories/ Floor # occupied by this business	Building Construction Type *(see below)
Location (1) ______________________ Street ______________________ City, State, Zip	______	______	______	________	______/______	______________
Location (2) ______________________ Street ______________________ City, State, Zip	______	______	______	________	______/______	______________
Location (3) ______________________ Street ______________________ City, State, Zip	______	______	______	________	______/______	______________

If more than 3 locations, please continue on separate sheet.

*Types of Building Construction that closely matches the description of building that Insured occupies.

Wood Frame, including masonry veneer	Tilt-up concrete
Un-reinforced masonry	Reinforced concrete
Reinforced masonry	Light gauge steel frame
Mobile home	Protected structural steel frame

Policy Specifications

Non Participating Plan:________ Participating:_____ Program:__________ Program Name: __________________________
Commission %__________ Direct Bill:______ Agency Bill:_______

Producer Authorized Signature ____ Date_________________