Republic Indemnity

RESIDENTIAL LIVING / 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 - Residential Living Centers

1. Detailed description of operations, and employees duties:
   _____
   _____
2. Is there any dispensing of medicine? Yes ○ No ○
3. Number of locations: _____ Average number of residents at each location: _____
4. Maximum Number or percent of ambulatory Residents/Average number of residents at each location: _____
   _____
   Number or percent of non ambulatory residents: _____
   Number or percent of residents with dementia: _____
   Number or percent of residents with Alzheimer's: _____
   What methods/aids are used for moving patients: _____
5. Are there any programs in place (Sharp, Bloodborne Pathogen, etc.) ? Yes ○ No ○ If yes, please describe details _____
   _____
6. Is there a housing exposure for full-time/part-time/seasonal employees? Yes ○ No ○
   If yes, is lodging provided to employees expressly in lieu of wages? Yes ○ No ○
7. Are the owners engaged in day to day operations? Yes ○ No ○
   Are any family members employed? Yes ○ No ○

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 while living on the premises? 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 ◯

Application/Policy #_____

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
    _____

15. Is there any out-of-state travel? Yes ◯ No ◯ If yes, who travels? _____
    Where do they travel? _____ How long do they travel for? _____

16. Does the applicant own, operate or lease aircraft: Yes ◯ No ◯
    *If yes, provide details*_____

17. 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*_____

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

	# Employees assigned to location (including those who work off premises)		# of Shifts	Maximum number of employees on premises at one time	# of Stories/ Floor # occupied by this business	Building Construction Type *(see below)
	Full-time	Part-time				
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_____