



RESIDENTIAL LIVING CENTERS
SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

Insured Name: Federal ID #: Application/Policy #:
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.

Table with 6 columns: 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

- 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:
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
7. Are the owners engaged in day to day operations? Yes No

General Information

- 1. Current number of permanent employees for each location:
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

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
- Un-reinforced masonry
- Reinforced masonry
- Mobile home
- Tilt-up concrete
- Reinforced concrete
- Light gauge steel frame
- Protected structural steel frame

Policy Specifications

Non Participating Plan: _____ Participating: _____ Program: _____ Program Name: _____
 Commission % _____ Direct Bill: _____ Agency Bill: _____

Producer Authorized Signature _____ Date _____