



## Art Hollingsworth Insurance Services

License # 0352964 (707) 584-5824 (707) 584-5828 / f

### Tips For Smoother Application Processing

The only forms you need to submit to us are:

- \* A completed Acord application #130
- \* Current valued loss runs for the past 4 years.
- \* Supplemental Application

The following list includes **all items necessary** to complete your application:

1. Applicants complete business name.
2. Your complete agency information with fax number.
3. Applicant's number of years in business.
4. Physical address, if more than one location list each one.
5. Applicant's federal identification number.
6. Check the type of business.
7. Effective date & expiration date. (ASAP will not suffice)
8. Use correct class code number. (for help call (415) 778-7000, WCIRB)
9. Correct class code description.
10. Number of employees. (separate number of full time and part time)
11. Payroll amounts for each code.
12. Check rate information to be sure it is current.
13. Complete all officer information (back page of work comp application).
14. Insurance carrier, claims and policy number for prior two years, if no prior carrier, please indicate. (current valued loss runs, 4 years, must accompany application)
- 15. All questions must be answered**

If this is a new business we will need a business plan resume' and a new venture supp app.  
Please request the supp app from [ron@hollingsworthinsurance.com](mailto:ron@hollingsworthinsurance.com).

# Work Comp Supplemental Application

Insured: \_\_\_\_\_ Eff. Date: \_\_\_\_\_  
 Contact Name & Title: \_\_\_\_\_ Tel. #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Website Address : \_\_\_\_\_

**GENERAL INFORMATION:**

Years in business: \_\_\_\_\_ # of locations \_\_\_\_\_  
 Description of operations \_\_\_\_\_  
 Union:  Yes  No If yes, name of Union \_\_\_\_\_  
 Current number of employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Volunteers \_\_\_\_\_  
 Percent of employee turnover in the last 12 months Full time \_\_\_\_\_ Part time \_\_\_\_\_  
 Employee staffing expectation over the next 12 months Full time \_\_\_\_\_ Part time \_\_\_\_\_  
 Average hourly wage in Governing Class: Full time \$ \_\_\_\_\_ Part time \$ \_\_\_\_\_  
 Average hourly wage in Clerical class: Full time \$ \_\_\_\_\_ Part time \_\_\_\_\_  
 Average hourly wage in Sales class: Full time \$ \_\_\_\_\_ Part time \_\_\_\_\_  
 Has the insured ever been in bankruptcy?  Yes  No If yes, explain \_\_\_\_\_

**BENEFITS:**

Are ALL employees eligible Y/N; if no then who? \_\_\_\_\_  

	% paid by employer	% of participation
Group Health <input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid sick leave <input type="checkbox"/> Yes <input type="checkbox"/> No	Vacation <input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement / Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No

 Name of Healthcare provider: \_\_\_\_\_  
 Do you use a specific: Clinic \_\_\_\_\_ Physician \_\_\_\_\_ Emergency room \_\_\_\_\_  
 CPR training provided?  Yes  No

**SAFETY PROGRAM:**

Safety program / IIPP compliant with SB 198  Yes  No  
 Return to light duty plan  Yes  No  
 Return to full time modified work plan  Yes  No  
 Designated full time safety director  Yes  No Name: \_\_\_\_\_  
 Safety meetings held for all employees  Yes  No Frequency of meetings \_\_\_\_\_  
 Safety training held for all employees  Yes  No Incentive program for employees  Yes  No  
 Personal protective safety equipment provided  Yes  No  
 Supervisors are held accountable for injuries / accidents  Yes  No  
 Accident investigation program in place  Yes  No  
 Do you have a Health & Wellness program?  Yes  No  
 Describe Health & Wellness activities: (eg. physical fitness and nutrition assessment and consultation, lifestyle health risk appraisal, discounted gym membership, walk-at-lunch program, weight loss/smoking cessation program, stress reduction, first aid, blood pressure management, physical demand validation of job descriptions, etc.) \_\_\_\_\_

**HIRING PRACTICES:**

Employment application <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No
Reference checks <input type="checkbox"/> Yes <input type="checkbox"/> No	Audiometric Testing <input type="checkbox"/> Yes <input type="checkbox"/> No
Motor Vehicle Record Check <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre/Post employment physical <input type="checkbox"/> Yes <input type="checkbox"/> No
Volunteer Labor used <input type="checkbox"/> Yes <input type="checkbox"/> No	Pathogenic test (i.e. lead ) <input type="checkbox"/> Yes <input type="checkbox"/> No
Temporary labor used <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic back test <input type="checkbox"/> Yes <input type="checkbox"/> No

**OPERATIONS:**

Hours of operation: \_\_\_\_\_ to \_\_\_\_\_ Number of daily shifts \_\_\_\_\_  
 Operation includes driving?  Yes  No Number of authorized drivers \_\_\_\_\_ No. of vehicles \_\_\_\_\_  
 Types of vehicles driven \_\_\_\_\_  
 Reason(s) for driving (delivery, sales calls, etc.)? \_\_\_\_\_  
 Frequency of driving: Daily  Weekly  Other   
 Driving radius: < 50 miles  51-100 miles  101-250 miles  250 miles   
 Frequency of MVR checks \_\_\_\_\_ Participation in CHP Pull program  Yes  No  
 Driver acceptability standards have been established  Yes  No  
 Vehicles inspection / maintenance program  Yes  No Frequency \_\_\_\_\_  
 Vehicle maintenance performed is performed by employees  Yes  No  
 Employees take vehicles home  Yes  No  
 Motor Carrier Permit (MCP) Filing Number: \_\_\_\_\_

**PAYROLL AND PREMIUM HISTORY:**

Payroll: Current year: \_\_\_\_\_ Premium: Current year: \_\_\_\_\_  
 1<sup>st</sup> Prior Year: \_\_\_\_\_ Premium: 1<sup>st</sup> Prior Year: \_\_\_\_\_  
 2<sup>nd</sup> Prior Year: \_\_\_\_\_ Premium: 2<sup>nd</sup> Prior Year: \_\_\_\_\_  
 3<sup>rd</sup> Prior Year: \_\_\_\_\_ Premium: 3<sup>rd</sup> Prior Year: \_\_\_\_\_  
 4<sup>th</sup> Prior Year: \_\_\_\_\_ Premium: 4<sup>th</sup> Prior Year: \_\_\_\_\_

Any travel out of Country/ State?  Yes  No No. of employees who travel: \_\_\_\_\_ Frequency \_\_\_\_\_  
 What Countries and/or States? \_\_\_\_\_  
 Purpose: \_\_\_\_\_

**HOTEL / MOTEL:**

Number of guest rooms: \_\_\_\_\_ Room rate: Under \$50  \$50-74.95  \$75-99  Over \$100   
 Food service: Operate own:  Yes  No Subcontract: Restaurant  Bar  Both   
 Gross receipts: Food % \_\_\_\_\_ Liquor % \_\_\_\_\_  
 Entertainment:  Yes  No Lounge:  Yes  No Armed Security:  Yes  No  
 Operation: Year round  Seasonal  Conference center:  Yes  No  
 Shuttle service:  Yes  No How many vans: \_\_\_\_\_ Flat rate per room   
 How are maids compensated: Salary  Hourly wage   
 Who flips the mattresses and how are they turned: \_\_\_\_\_

**RETAIL / WHOLESALE:**

Gross receipts: Wholesale % \_\_\_\_\_ Retail % \_\_\_\_\_ Compensation: Flat salary \_\_\_\_\_ Hourly wage \_\_\_\_\_  
 Type of merchandise \_\_\_\_\_ Commission \_\_\_\_\_  
 Palletized:  Yes  No Outside sales employees:  Yes  No  
 Lifting exposure or repackaging:  Yes  No Lbs: \_\_\_\_\_ Is there assembly:  Yes  No If yes, what? \_\_\_\_\_  
 Forklift exposures describe: \_\_\_\_\_

**MANUFACTURING & ASSEMBLING:**

Machine guarding: Point of operation:  Yes  No Material handling exposure:  Yes  No  
 Drive mechanism:  Yes  No Lifting:  Below 50 lbs.  Above 50 lbs.  
 Moving Parts:  Yes  No Lock out/tag out:  Yes  No Off premises operations:  Yes  No Percentage \_\_\_\_\_  
 % of - Point of operation guarding: \_\_\_\_\_  
 Moving parts Drive Mechanism: \_\_\_\_\_  
**TYPE OF MACHINES USED?** \_\_\_\_\_ Where / What: \_\_\_\_\_  
 Personal Protection Equipment provided?  Yes  No  
 Use enforced?  Yes  No  
 Any piece-work or home-based work?  Yes  No  
 If yes, explain: \_\_\_\_\_



**SERVICE STATIONS / AUTO REPAIR SHOPS / TRANSMISSION SHOPS:**

Hours of Operation \_\_\_\_\_  
 Gas operation:  Full Service  Self service  
 Repair operation:  Yes  No  
 Tire repair/installation  Over 1-ton truck (yes/no)  
 Towing:  Yes  No Contract tow:  Yes  No  
 Road Repair:  Yes  No  
 Mini-Market:  Yes  No Liquor sold?  Yes  No  
 Bullet proof cashier booth:  Yes  No  
 Drop safe or registers:  Yes  No  
 Car Wash:  Yes  No *If yes,*  self serve  full serve  
 Access to freeway:  0-1 mile  1-2 miles  2+ miles

**ATTORNEYS**

What type of law:  
 Any criminal law:  Yes  No Percentage Any insurance law:  Yes  No Percentage

**RESTAURANT:**

Average Entrée Price: \_\_\_\_\_  
 Liquor Receipts (% of gross receipts) \_\_\_\_\_  
 Entertainment:  Yes  No If yes, please provide details: \_\_\_\_\_  
 Catering:  Yes  No % of revenues: \_\_\_\_\_  
 Radius: \_\_\_\_\_  
 Delivery:  Yes  No % of revenues: \_\_\_\_\_  
 Radius: \_\_\_\_\_  
 Separate Lounge:  Yes  No  
 Twenty-four hour operation:  Yes  No  
 Multiple Floor levels  Yes  No  
 Number of: Hosts Valet Parkers  
 Waitpersons Bartenders  
 Cooks Take-out:  Yes  No

**APARTMENT OWNER OR OPERATOR:**

List of operations sub-contracted to others: \_\_\_\_\_  
 Current employees perform sub-contracted operations for you?  Yes  No *If yes, please list:*  
 The following items are maintained and kept current for all sub-contractors:  
 Certificate of workers' compensation insurance  Yes  No  
 Copy of each sub-contractor's license number  Yes  No

**JANITORIAL:**

Percentage of revenues from: Office Buildings Manufacturing Plants Medical Properties Other  
 Pressure cleaning?  Yes  No Concrete cleaning or sealing?  Yes  No Roof or gutter cleanup?  Yes  No  
 Window Washing requiring ladder or other device for heights  Yes  No Large Debris hauling  Yes  No  
 Other work requiring ladders  Yes  No Multiple Locations per night  Yes  No Group Transportation  Yes  No  
 Confined Space (vents, etc)  Yes  No Buffing waxing carpet cleaning  Yes  No

**FARMING OPERATIONS:**

Row Crops: % Trees/Vines: % Dairy/Cattle: %  
 Is housing provided?  Yes  No If yes, how many employees?  
 How many acres: 160 or less  161-499  500-999  1000+   
 Transportation of employees:  Yes  No If yes, how: Van  Bus  Other ; Frequency: Daily  Weekly  Monthly  Radius   
 Use Labor Contractor?  Yes  No  
 How are employees paid? Hourly rate Piece rate Combination Other  
 Dairy Barn: Elevated  Carousel  Flat  Other  
 Number of milking cows \_\_\_\_\_  
 Number of bulls \_\_\_\_\_ Number of bulls 3 years and older \_\_\_\_\_  
 Outside Veterinary Services  Yes  No  
 • Artificial Insemination:  Yes  No Subcontracted?  Yes  No  
 • Hoof trimming:  Yes  No Subcontracted?  Yes  No  
 • De-horning:  Yes  No Subcontracted?  Yes  No  
 • Does insured harvest for others?  Yes  No If yes, own equipment used?  Yes  No

**CONSTRUCTION: (Includes Landscapers and Artisan Contractors)**

Contractor's License # \_\_\_\_\_ Copy Included  Yes  No \_\_\_\_\_ Classification \_\_\_\_\_  
Detailed Description of Operation \_\_\_\_\_

Estimated Gross Receipts \_\_\_\_\_ Estimated Subcontractors Receipts \_\_\_\_\_  
Sub-contractors Certificates sent to agent?  Yes  No  
Residential % \_\_\_\_\_ Commercial % \_\_\_\_\_ Re-model % \_\_\_\_\_ New Contract % \_\_\_\_\_

Types of machinery and hand tools used \_\_\_\_\_  
Proper guarding & maintenance in place  Yes  No  
Any work performed above 2 stories:  Yes  No  
If yes, explain \_\_\_\_\_  
Any Roof Exposure:  Yes  No If yes, explain: \_\_\_\_\_  
Any Concrete Tilt-Up Work:  Yes  No  
Any work performed underground? :  Yes  No Max depth: \_\_\_\_\_  
If yes, explain: \_\_\_\_\_  
Details of Interior and/or Exterior work performed: \_\_\_\_\_

Any use of Cranes:  Yes  No If yes, explain \_\_\_\_\_  
Any use of Scaffolds:  Yes  No If yes, are the ee's certified? \_\_\_\_\_  
Safety training provided  Yes  No  
Details \_\_\_\_\_

Level of Supervision \_\_\_\_\_  
# of staff to Supervisors \_\_\_\_\_  
Personal protective wear available?  Yes  No Examples: \_\_\_\_\_  
Type of vehicles \_\_\_\_\_ # of Vehicles \_\_\_\_\_ Transportation of employees?  Yes No

# of Drivers \_\_\_\_\_  
Percentage of OCIP work anticipated in the upcoming year? % \_\_\_\_\_  
Percentage of OCIP work performed in the past 2 years? % \_\_\_\_\_

**Alcoholic and Drug Recovery Homes, Social Rehabilitation Facilities for Adults, Nursing Homes, Convalescent Homes or Convalescent Hospitals, Rest Homes, Sanitariums, Congregate Living Facilities for the Elderly, Hospitals, Residential Care Facilities for the Elderly, Residential Care Facilities for the Adults, Residential Care for the Developmentally Disabled**

Are the Insured facilities licensed?  Yes  No  
 If yes, by whom:  California Department of Social Services, or  \_\_\_\_\_.

**Occupancy**

	<u>No. of Beds Certified</u>	<u>Current Census</u>	<u>Level of Care</u>	<u>Current Census</u>
Medicare/Medicaid	<input type="text"/>	<input type="text"/>	Skilled	<input type="text"/>
Private Pay	<input type="text"/>	<input type="text"/>	Intermediate	<input type="text"/>
Total Beds	<input type="text"/>	<input type="text"/>	Independent Living	<input type="text"/>
			Total Beds	<input type="text"/>

Indicate the number of beds provided for residents with the following (included in the totals above)  
 Alzheimer/dementia  chemical dependency   
 HIV patients  mental retardation/ mental illness

Average census past 12 months for all residents:

Describe other services:

Home health care?  yes  no  
 Adult day care?  yes  no

Percentage (%) of ambulatory patients?

**Employees**

***EMPLOYEE BREAKDOWN***

	<u>Full Time</u>	<u>Part Time</u>		<u>Full Time</u>	<u>Part Time</u>
Management			Physical Therapy		
Clerical			Dietary		
RN's			Maintenance		
LPN's			Laundry		
CNA's			Other		
			Totals		

In past 12 months, how often has a Temporary Agency been used to meet staffing needs?  yes  no

**REFER TO BHHC SUPPLEMENTAL APPLICATION FOR NON - PROFITS**

Signed by:

Title:

Dated: