



Temporary Staffing Supplemental Application

Employer Name: _____

Employer Primary Contact: _____ Phone: _____

Email: _____ Website: _____

Descriptions of Operations: _____

Premium, Payroll and Experience Mod History

Please fill in the correct amount for each of the following:

	Expiring Year	Prior (1)	Prior (2)	Prior (3)	Prior (4)
Premium					
Payroll					
Experience Mod					

General Applicant Information

- What is the percentage of your anticipated annual growth for the upcoming year? _____
Details: _____
- Are you a new Venture? (If yes, attach all Sr. Executive resumes' and your Pro Forma Balance Sheet prepared by an accountant.) Yes No
- Have you conducted business in your present territory for at least 3 years? (If no, provide details.) Yes No
Details: _____
- Do you provide any assignments that are not temporary in nature (i.e. that do not have an end date)? Yes No
If yes, explain: _____
- Are you required to be licensed or register as a PEO (Professional Employer Organization) in any of the states in which you operate? Yes No
- Do you provide any PEO services? Yes No
If yes, explain: _____
- Are there any other commonly owned businesses that are separately insured? Yes No
If yes, explain: _____
- Are there any states in which you operate that are covered elsewhere? Yes No
If yes, explain: _____
- Do you hire day laborers? Yes No
- Do you provide group transportation? Yes No
- Do you employ 100 or more workers at any single work location? Yes No

12. Do you have any outstanding WC premium or audit issues from the last three policy terms? Yes No
If yes, explain: _____
13. Do you supply workers to construction operations in California? Yes No
14. Do any of your clients have exposures to Maritime operations subject to the USL&H Act, the Admiralty Law or the Outer Continental Shelf Lands Act? Yes No
If yes, explain: _____
15. Do any of your clients have exposures to the following Acts: Migrant and Seasonal Agricultural Worker Protection Act, Federal Employers' Liability Act, Federal Coal Mine Health & Safety Act, Defense Base Act? Yes No
If yes, explain: _____
16. Are you requesting Employer's Liability ("Stop Gap") in any of the following states: ND, OH, WA and WY? Yes No
If yes, provide annual premium for each state: _____

17. Do you have foreign travel exposures? Yes No
If yes, provide details concerning countries, duration, and number of employees: _____

18. Do you accept other temporary staffing agencies as clients (i.e. piggyback arrangements)? Yes No
If yes, provide details and payroll associated with these clients: _____

Employee Screening

Does your New Hire Program include the following:	Details:
1. Formal written job application <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Criminal Background Checks <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Reference checks <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Motor Vehicle checks on drivers <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Job experience & placement certification requirements <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Pre-employment physicals <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Pre-employment drug testing <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Probationary period <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Minimum Experience Requirements <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Any additional information. If yes, provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No	



Employee Benefits

Does your Employee Benefits Program include the following:	Details:
1. Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Long-Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Short-Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Paid Vacation Days <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Paid Sick Days <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Employee Assistance Program <input type="checkbox"/> Yes <input type="checkbox"/> No	

Client Information

Average Number of New Clients added annually?: _____

Client Exposure Breakdown (List the number of clients and the total number of employees you have for each industry.)

	# of Clients	# of Employees
Light Industrial:		
Heavy Industrial:		
Construction (Trade):		
Construction (General):		
Wholesale / Retail:		
Clerical (Professional):		
Clerical (General):		
Medical:		

Total # of Full-Time Office Staff: _____

Total # of Temporary Placements Last Year: _____

of W2's: _____ # 1099's: _____

Do you require independent contractors to carry their own workers compensation coverage? Yes No

If no, please explain reasoning: _____

Profile of the Five Clients with the Highest Number of Employees You Provide:

Customer Name	Description of work performed by your employees	Class Code	State	Payroll	Clients # of Employees	# of Temp

Client Screening

		Details:
1.	Do you have established criteria for new client selection? If yes, provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	Do you complete job hazard assessments for all new clients or new tasks? If yes, provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Do you have procedures in place to eliminate clients for poor safety practices or loss experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	Do you review the client's new worker orientation procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Do you review client's response procedures for emergency or accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Do you inspect worksites for safety "prior" to employee placement? (If yes, please provide inspection template.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Do you or the client provided employees with a description of the job assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	Do you or the client provide safety training? If yes, provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No	

Safety Management By Applicant

Does your Safety program include the following:		Details:
1.	Written Safety Plan? (If yes, please provide table of contents.) <input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	Full time safety director? If yes, provide name, title and duties. <input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Safety committee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	Accident investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Employer provided safety equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Employee training for lifting, ergonomics, universal precautions? <input type="checkbox"/> Yes <input type="checkbox"/> No	

7. Employee safety meetings?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Loss Control/Safety incentives?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Light duty / early return to work program? (If yes, please provide a copy.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Random drug testing program	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Claims Management And Reporting

Does your Claims Management program include the following:	Details:
1. Full time claims manager	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Claims fraud investigator	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Established injury reporting procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Require all WC claims to be reported within 24 hrs.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Drug testing after an injury occurs. If yes, provide details on procedure.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. A process to identify claims frequency and claims trends	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Mid term monitoring and reporting of trends in claim frequency and severity	<input type="checkbox"/> Yes <input type="checkbox"/> No

Healthcare Staffing (Complete only if making Healthcare placements.)

- Please provide the percentage (%) of payroll for the environments in which Healthcare Staffing is conducted:

_____ Dental Office	_____ Doctor's Office	_____ Hospitals
_____ Manufacturing Facility	_____ Nursing/Assisted Living Home	_____ Prison
_____ Private Homes	_____ Psychiatric Facility	_____ School
_____ Other (Please Specify): _____		
- Percentage (%) of placements in the following occupations:

_____ RNs	_____ LPNs	_____ CNAs
_____ Doctor/Dentist	_____ Homemaker/Home Aid	_____ Infusion Therapist
_____ Lab Techs	_____ Occupational Therapist	_____ Physical Therapist
_____ Physician's Assistant	_____ Social Worker	_____ Speech Therapist
_____ Other (Please Specify): _____		
- Do you provide traveling nurses? Yes No
 Do the employees leave the state you are headquartered in? Yes No
 If yes, are all states listed on the ACORD with payroll? Yes No
- Does the written safety program include the following?

OSHA Bloodborne Pathogens <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B Vaccine Services Offered <input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Protective Equipment Requirements <input type="checkbox"/> Yes <input type="checkbox"/> No	OSHA Needlestick Safety and Prevention <input type="checkbox"/> Yes <input type="checkbox"/> No
- Do you conduct pre-placement physical exams on all prospective hires involved in patient or client care? Yes No

6. Are employees required to lift or physically transfer patients?

Yes No

Applicant Signature

Notice: This application is for the purpose of obtaining a quotation and does not bind the applicant or the Company to provide the insurance. The Undersigned declares that to the best of his/her knowledge, the statements set forth herein are true. If the information supplied herein changes between the date completed and the effective date of the insurance, the undersigned shall notify the Company of the changes and the Company reserves the right to modify or withdraw any offer for insurance.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or, conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject such person to criminal and civil penalties.

Applicant Name: _____

Applicant Signature: _____ **Date:** _____

Producer Signature: _____ **Date:** _____