

# Non Profit Worker's Compensation Supplemental Application



## Contact Information

Insured:  Effective Date:  FEIN No.:

Contact Name & Title:

Phone Number:  Fax Number:  Contact E-mail:

## General Information

Years in Business:  No. of Locations:  Hours of Operation:  to:

Description of Operations:

- Does the Insured operate a retail, resale or thrift store?  Yes  No
- Does the retail, resale or thrift store accept electronics, appliances and/or furniture?  Yes  No
- Do they offer pick up service for the items above?  Yes  No
- Does the agency operate a sheltered workshop?  Yes  No

Number of Clients:  Describe operations of sheltered workshop:

Present number of Employees: Full-Time:  Part-Time:  Seasonal:  Volunteers:

Percent of employee turnover in last 12 months: Full-Time:  Part-Time:

Employee staffing expectation over the next 12 months: Full-Time:  Part-Time:

Average hourly wage: Full-Time: \$  Part-Time: \$

Benefits Provided - are ALL employees eligible?  Yes  No If not, WHO is eligible?

	<input type="radio"/> Yes <input type="radio"/> No	% Paid by Employer	% of Participation
Group Health	<input type="radio"/> Yes <input type="radio"/> No		
Paid Sick Leave	<input type="radio"/> Yes <input type="radio"/> No		
Vacation	<input type="radio"/> Yes <input type="radio"/> No		
Retirement/Pension Plan	<input type="radio"/> Yes <input type="radio"/> No		

Name of Healthcare Provider:

Provide name of clinic, physician, or emergency room used for workplace related injury:

Full-time nurse maintained on staff?  Yes  No CPR training provided?  Yes  No

Would you be willing to participate in a MPN (Medical Provider Network) program to control claim costs?  Yes  No

Safety activities currently established and practiced regularly?  Yes  No Written safety program compliant with state labor codes?  Yes  No

Return to light duty plan?  Yes  No Includes full wages?  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:

Safety training held for all employees?  Yes  No Incentive program for employees?  Yes  No

Personal protective safety equipment provided for all employees where necessary?  Yes  No

Supervisors are held accountable for injuries/accidents?  Yes  No Accident investigation program in place?  Yes  No

**Hiring Practices:**

Employment application?  Yes  No      Drug/substance abuse?  Yes  No  
 Reference checks?  Yes  No      Audiometric testing?  Yes  No  
 Pre/Post employment physical?  Yes  No      Orthopedic back test?  Yes  No

## Vehicle Use

Operations include vehicle exposure (Company owned or personal)?  Yes  No      # of Authorized Drivers:       # of Vehicles:

For what purpose do employees drive?

Frequency of driving:  Daily  Weekly  Other      Driving radius:  < 50 miles  51-100 miles  101 - 250 miles  > 250 miles

Frequency of MVR checks:       Participation in an MVR Pull program?  Yes  No

Driver acceptability standards established?  Yes  No      Vehicle inspection/maintenance program?  Yes  No      Frequency:

Any BIT inspections with unsatisfactory rating?  Yes  No      Employees take vehicles home at night?  Yes  No

Vehicle maintenance performed by employee?  Yes  No      If NO, who:

How many vehicles have a capacity of 15 passengers or more?       No. of employees allowed to ride in 15 passenger vehicles, at one time?

Do company vehicles transport any non-employee passengers?  Yes  No      Clients only?  Yes  No

Do you have a driver safety program?  Yes  No      If YES, please provide copy

For vehicles with passenger capacity > 15 passengers or over 10,000 GVW, please complete the following:

Year	Make & Model	Garage Location	Driving Radius	Ann. Mileage Driven	Gross Veh. Weight	Retail Deliveries
						<input type="radio"/> Yes <input type="radio"/> No
						<input type="radio"/> Yes <input type="radio"/> No
						<input type="radio"/> Yes <input type="radio"/> No

Provide a list of the drivers of the 15 passenger or mor vehicles, including name, driver's license number and MVR's (or attach copy)

Driver Full Name	Driver's License

## Payroll and Premium History

	Payroll	Premium
Current Year		
1st Prior Year		
2nd Prior Year		
3rd Prior Year		
4th Prior Year		

Send submissions to [Submissions@tangramins.com](mailto:Submissions@tangramins.com).

Phone: 1-800-676-2213 \* Fax: 707-781-7351