Social Service Workers' Compensation Supplemental Application

Contact Information

Insured: ______ Effective Date: ______ FEIN No.: ______

Contact Name &: Title ______

Phone Number: ______ Fax Number: ______ Contact E-mail: ______

Payroll and Premium History

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

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? ______

			% Paid by Employer	% of Participation
Group Health	◯ Yes	◯ No		
Paid Sick Leave	◯ Yes	◯ No		
Vacation	◯ Yes	◯ No		
Retirement/Pension Plan	◯ Yes	◯ 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
						◯ Yes ◯ No
						◯ Yes ◯ No
						◯ Yes ◯ 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**

Send submissions to **Submissions@tangramins.com**.
Phone: 1-800-676-2213 * Fax: 707-781-7351