

WORKERS COMPENSATION AUTOMOTIVE SUPPLEMENTAL APPLICATION

(To be completed with Acord 130 application)

Named Insured: _____ Web Address: _____

Insured's FEIN: _____

Contact Name and Phone Number

Inspections: _____ ()

Premium Audit: _____ ()

Claims: _____ ()

Prior Payroll and Premium Information

	Total Annual	Payroll Premium \$
Current Year:	_____	_____
Prior Year:	_____	_____
Prior Year:	_____	_____
Prior Year:	_____	_____
Prior Year:	_____	_____

Operations and Benefits

Broker controlled account? Yes No

Please provide a detailed description of the operation: _____

Years in business? _____ Hours of operation _____ to _____

Is there a driving/delivery exposure? Yes No If yes, what is frequency: Daily Weekly Other:

Radius of operations/travel: <50 miles 50-100 100+

Any group transportation of employees? Yes No If yes, how provided? Car Truck Van Bus

Is a PUC/DMV filing required? PUC DMV N/A Are vehicles company owned? Yes No

Number of employees transported per vehicle _____

Any day laborers or temporary/employee leasing? Yes No If yes, please provide details on separate page.

How are employees paid? Hourly Piece rate Commission Salary Other:

% of union employees _____ % of non-union _____ If union, Exp. date of contract _____

Paid sick leave? Yes No Paid vacation? Yes No

Actual average hourly wage for employees in governing class \$_____/hour

Group medical provided? Yes No If yes, name of health care provider: _____

% of employees enrolled _____ % paid by employer _____

Has the ownership of the applicable entity changed within the past 5 years? Yes No

If yes, please provide details: _____



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Hiring Practices – Employee Selection - Claims

Written application? Yes No
Reference checks? Yes No
Pre/post employment Physicals? Yes No
Orthopedic back testing? Yes No
Formal job descriptions on file? Yes No
Are personnel files documented for pre-existing injuries? Yes No
Are there set procedures for reporting claims? Yes No
Any Interchange of labor? Yes No If yes, please explain Another business Subsidiary Between departments
 Other: _____
Subcontractors used? Yes No If yes, for what purpose? _____
If yes, are certificates of insurance obtained and kept on file? Yes No
Independent contractors used? Yes No If yes, for what purpose? _____
If yes, how are they paid? 1099's Other – Please explain: _____

Safety Program and Organization – Work Premises and Environment

Are owners active in daily operations? Yes No If yes, are they excluded from coverage? Yes No
Active injury & illness prevention program? Yes No
Has loss control services been performed in the last year? Yes No
Active safety incentive program? Yes No If yes, does it encompass all employees? Yes No
What type of incentive? _____
Has Cal/OSHA visited or cited your business in the last year? Yes No If yes, please provide explanation on separate page.
Are safety meetings conducted? Yes No
Do employees receive safety training/orientation? Yes No If yes, how often? Daily Weekly Monthly Quarterly
If yes, is the training Formal / Documented Informal Other: _____
Do you have a safety director or risk manager? Yes No Name and title: _____
If yes, is the position full time or an additional responsibility of another employee? _____
MSDS (Material Safety Data Sheets) available for all chemicals and products used? Yes No NA
Any material handling exposures? Yes No If yes, please explain _____
Any lifting exposures? Yes No Forklift training provided? Yes No NA
If yes, <25 lbs. 25-40 40+ If yes, annual certification? Yes No
If 40+, manual lifting or with assistance? Please explain _____

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Is all machinery/equipment properly guarded? Yes No NA Any use of baler equipment? Yes No
Condition of equipment? New Good Average Are all equipment operators trained/certified? Yes No NA
Personal protection equipment provided? Yes No NA
Written lock out / tag out / block out procedures in place? Yes No NA
Respiratory program in place? Yes No NA If yes, strict enforcement of utilization? Yes No
What is the maximum height at which you will work? _____ What types of PPE? _____
What is used? Ladder Scaffolding Scissor lifts N/A
If scaffolding used, does the insured build their own? Yes No
Is the building / premises Owned or Leased? # Of years at current location? _____
Condition of premises? Excellent Very good Average Age of building occupied? _____ year(s)

Automotive Services

Any towing services provided? Yes No If yes, any contract towing? Yes No
Any road repair assistance? Yes No If yes, 24 hour exposure? Yes No
Is there a mini-market on premises? Yes No Any fueling operations? Yes No
If yes, any sales of alcoholic beverages? Yes No Any security/surveillance cameras on premises? Yes No
Open 24 hours? Yes No Any test driving of customers' vehicles? Yes No
Is cashier's booth bullet proof? Yes No Any transportation of customers? Yes No
Access to freeway? 0-1 mile 1-2 miles 2+ miles
Any off-premises or mobile services? Yes No If yes, provide details including percentage of payroll dedicated:

Do you have a ventilated/filtered spray booth for painting operations? Yes No NA
Do you have a written respiratory protection program? Yes No NA
Are employees properly trained in the use and care of respiratory protection equipment? Yes No NA
Has proper fit testing been provided to each employee and their assigned respirator? Yes No
Are employees ASE trained and certified? Yes No If yes, how many employees? _____

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Note: All information provided is subject to verification by way of an underwriting survey or inspection. We must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation of information provided is inaccurate.

WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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 insurance act, which is a crime and subjects the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR or VT. In DC, LA, ME, TN, VA and WA insurance benefits may also be denied). In Florida, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Colorado Disclosure: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

I Have Read And Understood All Of The Questions Asked And Have Provided All Information Required.

Signature of Applicant: _____ Date: _____

