



REGENCY INSURANCE
BROKERAGE SERVICES

Supplemental WC Application – Health Care

Instructions:

- Please type or print clearly in ink. All sections must be completed fully.
- If you need more space, attach additional sheets as needed using company letterhead

1. APPLICANT OVERVIEW

Firm Name: _____

(If the insured has a DBA please list)

Date business established: _____ Number of years under current ownership: _____

Website URL is: www._____

- a) Are medical/health insurance benefits provided to employees? Yes No
- b) Are more than 75 employees located at any one location at any one time _____ Yes No
- c) Indicate annual turnover rate: _____ %
- d) Do any employees work longer than a 12 hour shift? Yes No
If yes, please provide details: _____
- e) Indicate percentage of volunteers in the workforce: 0% 1 – 10% 11 – 40% > 40%

Business Operations (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Home Health - Skilled Nursing | <input type="checkbox"/> Substance Abuse Counseling | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Personal Care Provider | <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> Assisted Living |
| <input type="checkbox"/> Hospice Provider | <input type="checkbox"/> Crisis Response Team | <input type="checkbox"/> Community Hospital |
| <input type="checkbox"/> Physical Therapy / Occ. Health | <input type="checkbox"/> Drug Treatment / Detox | <input type="checkbox"/> Clinic |

Please indicate where your employees perform their work:

- | | | |
|---|---|--|
| <input type="checkbox"/> Private Homes/Apt. _____ % | <input type="checkbox"/> Clinics _____ % | <input type="checkbox"/> Nursing Homes _____ % |
| <input type="checkbox"/> Doctor's offices _____ % | <input type="checkbox"/> Hospitals _____ % | <input type="checkbox"/> Corporate offices _____ % |
| <input type="checkbox"/> Day Care Setting _____ % | <input type="checkbox"/> Community Residences _____ % | <input type="checkbox"/> Other Locations _____ % |

Please specify if other: _____

2. RISK MANAGEMENT AND SAFETY PROGRAMS

- a) What is the average radius that employees drive during the workday? _____ miles
- b) Do more than 3 employees travel together in any one vehicle? Yes No
- c) Are MVRs checked annually for all employees who drive as part of their job? Yes No
- d) What standard are traveling employees held to regarding MVRs: No violations in the last 3 years and/or No more than _____ violations in the last 3 years.
- e) Is a formal safety program in place? Yes No

f) Indicate the following safety practices the applicant has in place:

- | | | |
|---|---|---|
| <input type="checkbox"/> Driver Safety Programs | <input type="checkbox"/> Accident/Injury Investigation | <input type="checkbox"/> New Employee Orientation |
| <input type="checkbox"/> Safety Committee | <input type="checkbox"/> Patient Handling/Transfer Training | <input type="checkbox"/> Blood Borne Pathogen |
| <input type="checkbox"/> Safety Incentive Program | <input type="checkbox"/> Performance Evaluations include safety | <input type="checkbox"/> Combative Patient Training |
| <input type="checkbox"/> Regular Formal Safety Training Conducted | | |
| <input type="checkbox"/> Management involvement in safety (describe below if checked) | | |

Hiring Practices:

Check the following boxes to indicate screening measures that are applied to prospective employees (note: some are post offer)

- | | | |
|---|--|--|
| <input type="checkbox"/> Reference Check | <input type="checkbox"/> Validate Work History | <input type="checkbox"/> Personal Interviews |
| <input type="checkbox"/> Drug Testing/Screening | <input type="checkbox"/> Criminal Background Check | <input type="checkbox"/> Verification of Certifications/licenses |
| <input type="checkbox"/> Post-Offer Physicals | <input type="checkbox"/> Child Abuse Clearance | <input type="checkbox"/> Psychological Testing |

Claims Management:

- | | | |
|---|------------------------------|-----------------------------|
| a) Is there a designated person to manage workers' compensation claims? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Is there a formal Return to Work/Modified Duty Program in place? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Have detailed light duty job descriptions been developed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Has a relationship been established with a preferred medical provider? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

3. INSURANCE INFORMATION

- | | | |
|---|------------------------------|-----------------------------|
| a) Has the applicant had continuous WC coverage for the past 2 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Has the applicant's WC ever been cancelled for Underwriting Reasons?
If Yes, what is the reason _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Is the applicant's current WC insurance provided through an Assigned Risk Plan? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) Does the applicant supply any workers to other employers on a temporary or permanent basis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) Are all the applicant's operations (exclusive of monopolistic states) being submitted for WC? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

To the best of my knowledge all the information I have given about my business is true and correct. If information is found to be different as the result of my knowingly attempting to defraud the insurance company, or information is concealed for the purpose of misleading, or another person files an application for insurance containing materially false information the insurance company may send direct notice of cancellation.

Applicant Signature

Date

Agent Signature

Date