EMPLOYERS℠
EMPLOYERS INSURANCE GROUP
Experience You Can Trust
Employers Compensation Insurance Company

WORKERS COMPENSATION SUPPLEMENTAL APPLICATION

Named Insured:		**App/Policy Number:**		**Eff Date**	
Agency/Brokerage Firm:	**Lemark Insurance**	**Attn**:	**Mark Polak**	**Fax No**	
From:	**Alan Kilmartin**	**Phone No**	(818) 502-5238	**Fax No**	(818) 502-5245

Employee Benefits:

A. Medical Insurance: **Carrier** _____
- ☐ Employer pays 80% or more of All Employees
- ☐ Employer pays 50% or more of All Employees
- ☐ Employer pays 49% or less of All Employees
- ☐ Benefits provided only to Management & Supervisors
- ☐ No Medical Benefits provided

B. Employer paid Vacation? Yes ☐ No ☐

C. Employer paid Sick Leave? Yes ☐ No ☐

Employee Management:

A. Pre-Hire Screening:
- Applications: Yes ☐ No ☐
- Reference Checks Yes ☐ No ☐
- Physical Examinations: Yes ☐ No ☐

B. Pre-employment Drug Testing Yes ☐ No ☐

C. Post Accident Drug Testing Yes ☐ No ☐

Employee Profile:

A. Union Yes ☐ No ☐

B. No. of W2's filed for last reporting period:_____
- Starting Wage per hour: $_____
- Average Wage per hour: $_____
- # Permanent Employees: _____ #Full Time_____ #Part Time:_____
- **Class**: _____ **#EE's** _____ **Payroll** _____ **Class:** _____ **#EE's** _____ **Payroll** _____
- **Class**: _____ **#EE's** _____ **Payroll** _____ **Class:** _____ **#EE's** _____ **Payroll** _____
- # Temp/Seasonal Employees: _____
- Employee Turnover per year: _____
- Average # of years with Company: _____

C. Interchange of labor (if yes, existence of physical separations) _____

D. Percent of payroll for "off premises" operations: _____%
Operations performed off employer's premises:_____

E. No. of Company Vehicles: _____ No. of Drivers: _____
Radius of Driving Operations: _____ MVR's Checked: Yes ☐ No ☐
How often are MVR's run: _____ per year.

F. Do Employees drive their personal autos on Company Business: Yes ☐ No ☐

G. Are Employees allowed to use motorcycles on Company Business: Yes ☐ No ☐

H. Hours of Operation _____

I. Any weekend, nightshifts or graveyard shifts? Yes ☐ No ☐

J. Early Return to Work Program? Yes ☐ No ☐

Employee Safety Program:

A. New Employee Orientation Plan Yes ☐ No ☐

B. Formal Written Safety Program Yes ☐ No ☐

C. Documented Safety meetings with all Employees? Yes ☐ No ☐

D. Safety Incentive Plan Yes ☐ No ☐

E. Written Supervisor Accountability Plan Yes ☐ No ☐

F. Full Time Safety Director/Risk Manager — Yes ☐ No ☐
G. Employee Training Program for all employees? — Yes ☐ No ☐
H. Documented Physical Inspections of premises — Yes ☐ No ☐
I. Maximum weight lifted manually _____lbs
Controls (back belts, forklifts) _____
List mechanical lifting devices used: _____
J. Machine safety guards in place: — Yes ☐ No ☐
K. Lockout/Tag-out Program in place? — Yes ☐ No ☐
L. Personal Protective Equipment provided and usage enforced? — Yes ☐ No ☐
M. Documented Accident Investigation? — Yes ☐ No ☐
N. Formal Disciplinary Procedure in place? — Yes ☐ No ☐

Employee & Payroll Trends:

A. Future Staff Increases: _____ Future Staff Decreases: _____
B. Future Layoffs Foreseen: Yes ☐ No ☐

Management:

A. Owners: Active in Management: Yes ☐ No ☐
Absentee: Yes ☐ No ☐
B. Trade Associations:_____
C. Group Transportation Provided: Yes ☐ No ☐
D. Ratio of Supervisors to Employees: _____
Average # of year's experience:_____
Average # of years with Company: _____

Please only send the following additional information if there is a check mark in the checkbox.

Claims:

Please forward the following year's loss information to us:
Valuation date should be within 90 days of the policy inception date.

☐ 2003 to 2004 ☐ 2002 to 2003 ☐ 2001 to 2002 ☐ 2000 to 2001 ☐ 1999 to 2000

☐ For all claims over $25,000, please advise the following:
What was the injury?
How did it occur?
What corrective action has the insured taken to prevent recurrence?

☐ Please send us a current experience modification worksheet

Payrolls: Please forward the following Final Audited Payroll Totals to us:			**Premium:** Please forward the following Final Audited Premium information to us:	
☐	2003 to 2004		☐	2003 to 2004
☐	2002 to 2003		☐	2002 to 2003
☐	2001 to 2002		☐	2001 to 2002
☐	2000 to 2001		☐	2000 to 2001
☐	1999 to 2000		☐	1999 to 2000

Insured's Website Address

Additional Information/Comments:

_____

_____

Please return this Questionnaire by: _____

Completed By:_____ **Date:** _____

Title: _____