



DAYCARE SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

Application/Policy #: Effective Date: Insured Name: Federal ID #: Website: Email: Agency Name: Contact:

Payroll Data: Provide historical payroll data by class (for current and prior 4 years) or submit final audit invoices if available. Applicable only to policy years not insured by Republic Indemnity.

Table with 10 columns: Class, Class, Class, Class, Class, Class, Class, Class, Class, Class. Rows include Current Year, 1st Year Prior, 2nd Year Prior, 3rd Year Prior, 4th Year Prior.

Loss Experience

If the insured has not been insured by Republic Indemnity for the latest 3-year term, please attach currently valued loss runs for any of those three years insured elsewhere and most current experience modification worksheet if available.

Operational Information

- 1. Detailed description of operations: Age range that the facility is licensed for: Is the insured a Non-Profit entity? Yes No Hours of Operation: 2. Does the insured handle "special needs" children? Yes No If yes, provide details, including number of children: 3. Any residence-based facilities or in-home day care? Yes No If yes, provide details: 4. Is the facility operated by a religious organization? Yes No If yes, provide details:

Staffing

- 1. Current number of permanent employees: Number of Managers/Supervisors: Number of employees under 18: If any are under 16, work permits on file? Yes No Number of temporary/seasonal employees: Are any relatives employed? Yes No Does the insured utilize the services of Temporary Staffing Agencies or Labor Contractors? Yes No If yes, do they require contract language that specifies that the Agency/Contractor provides Workers' Compensation? Yes No Number of W2's filed for latest reporting year: 2. Average Hourly Wage: 9059 Full-time: \$ Part-time: \$ 8810 Full-time: \$ Part-time: \$



3. How many independent contractors are used? \_\_\_\_\_  
 How many 1099 forms are issued to individuals? \_\_\_\_\_  
 How many 1099 forms are issued to companies/organizations? \_\_\_\_\_  
 If there are independent contractors, what kind of work do they perform? \_\_\_\_\_  
 Are independent contractors covered under a statutory Workers' Compensation Insurance policy and do they provide Certificates of Insurance? Yes No
4. Number of employees: Increasing \_\_\_\_\_ Decreasing \_\_\_\_\_ Stable \_\_\_\_\_
5. Are volunteers used? Yes No  
 If yes, provide number of volunteers: \_\_\_\_\_ Details: \_\_\_\_\_
6. Does the insured prepare meals on premises? Yes No  
 If yes, provide details: \_\_\_\_\_
7. Are there any janitorial and/or maintenance employees? Yes No  
 If no, who provides the maintenance for the facility? \_\_\_\_\_
8. Designated full-time safety director? Yes No Name: \_\_\_\_\_
9. Safety meetings held for all employees? Yes No Frequency: \_\_\_\_\_
10. Accident investigation program in place? Yes No
11. Group Medical: Yes No Name of Group Medical Provider: \_\_\_\_\_  
 % of employees participating: \_\_\_\_\_ % of employer contribution: \_\_\_\_\_  
 Paid Vacation: Yes No Paid Sick Leave: Yes No 401K or Pension: Yes No

**Hiring**

1. Do you meet all state and federal hiring procedures to include fingerprints and background checks? Yes No
2. Drug Screening Program/Random Drug Testing: Yes No
3. Pre-employment physicals: Yes No
4. Does insured offer modified work? Yes No
5. Is there a probationary period? Yes No Length of time: \_\_\_\_\_ days

**Auto**

1. Does insured transport children? Yes No
2. Vehicle Exposure: Yes No Radius of Operations: \_\_\_\_\_ miles MVR's checked: Yes No  
 If yes, provide number of autos: \_\_\_\_\_ Type of autos: \_\_\_\_\_
3. Does insured provide field trips and/or off-premise activities? Yes No  
 If yes, average number of trips per year: \_\_\_\_\_ Any over night trips? Yes No  
 Describe the mode of transportation: \_\_\_\_\_
4. Does applicant own, operate or lease an aircraft? Yes No  
 If yes, provide details: \_\_\_\_\_
5. Are any of the insured's operations located within a Federal or State government owned building that is over 35% occupied by governmental offices or National Landmarks? Yes No  
 If yes, provide details: \_\_\_\_\_



**Locations(s) – Please complete for all locations of business operations:**

Number of Employees assigned to the location (including those who work off premises)		# of Shifts	Maximum number of employees on the premises at one time	# of Stories and Floor # occupied by this business		Building Construction Type *(see below)
Full-time	Part-time			# Stories	Floor #	

<b>Location (1)</b>						
Street						
City, State, Zip						

<b>Location (2)</b>						
Street						
City, State, Zip						

<b>Location (3)</b>						
Street						
City, State, Zip						

**If there are more than 3 locations, please continue on a separate sheet.**

\*Types of Building Construction that closely matches the description of the building that the insured occupies.

Wood Frame, including masonry veneer	Tilt-up concrete
Unreinforced masonry	Reinforced concrete
Reinforced masonry	Light gauge steel frame
Mobile home	Protected structural steel frame

**Policy Specifications**

Non-Participating Plan                      Participating  
 Program: Yes            No                      If yes, Program Name: \_\_\_\_\_  
 Commission: \_\_\_\_\_ %            Direct Bill            Agency Bill

Producer Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_