Republic Indemnity®

PHYSICIAN'S OFFICES 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.**

	Class 8834 (CA)	Class 8832 (NCCI)	Class	Class	Class
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. Type of practices/specialty, please, provide details: _____
   _____
2. Are any of the following services provided: Number of employees involved: _____
   - Lab Work Yes ◯ No ◯ # of Full-Time _____ # of Part-Time _____
   - Physical or Occupational Therapy Yes ◯ No ◯ # of Full-Time _____ # of Part-Time _____
   - Chiropractic Yes ◯ No ◯ # of Full-Time _____ # of Part-Time _____
   - Urgent Care/Emergency Services Yes ◯ No ◯ # of Full-Time _____ # of Part-Time _____
   - Outpatient Surgery Yes ◯ No ◯ # of Full-Time _____ # of Part-Time _____
3. Are there any programs in place (Sharp, Bloodborne Pathegon, etc.)? Yes ◯ No ◯
   If yes, please provide details: _____
4. What patient handling procedures are in place? _____

General Information

1. Current number of employees:
   - Physicians: Full-Time _____ Part-Time _____
   - Nurse/Med Support: Full-Time _____ Part-Time _____
   - Admin/Clerical: Full-Time _____ Part-Time _____
   - Number of temporary/seasonal employees: _____
   - Number of W2's filed for latest reporting year: _____

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2. **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 ◯
3. Number of employees: Increasing _____ Decreasing _____ Stable _____
4. Mean Wage: For mainstream employees in production operations or services offered $_____/hr.
   For administrative staff (e.g. clerical, sales) $_____/hr.
5. Union ◯ Non-Union ◯ % of employees participating: _____
6. Number of employees working from home: _____
   Average number of days per week working from home: _____
7. 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 ◯
8. Safety Program: Yes ◯ No ◯
   Safety meetings held for all employees: Yes ◯ No ◯
   Personal protective safety equipment provided: Yes ◯ No ◯
   Accident investigation program in place: Yes ◯ No ◯
9. Hiring Practices
   Application: Yes ◯ No ◯
   Check References: Yes ◯ No ◯
10. Pre-employment physical: Yes ◯ No ◯
11. Drug Screening Program/Random Drug Testing: Yes ◯ No ◯
12. Does insured offer modified work: Yes ◯ No ◯
    If yes, provide details: _____
13. Loss Control Incentive Program: Yes ◯ No ◯
14. Percent of Off Premise Operations: _____%
15. Vehicle Exposure: Yes ◯ No ◯ Radius of Operations: _____
    Number of Commercial Vehicles: _____ Number of Private Passenger Vehicles: _____
    Details of use, including specifics regarding delivery exposure and towing/roadside assistance, if applicable:
    _____
    Number of employees driving on a regular basis (we define regular as 10% or more of employees' time): _____
    Frequency of off-premises activity: Daily ◯ Less than Daily ◯
    What are the average and maximum number of covered employees that travel together in the same vehicle?
    _____
    How often do the maximum number of covered employees travel together in the same vehicle? _____
    MVR's checked: Yes ◯ No ◯ If yes, please provide details as to procedures in place: _____
    _____
    Is there a disciplinary/termination rule in place based on driving record? Yes ◯ No ◯
    If yes, describe how this is implemented: _____
16. What is the maximum manual weight lifted? _____ What material handling aids are used? _____
17. Hours of Operation: _____
18. Does applicant own, operate or lease aircraft? Yes ◯ No ◯
    If yes, provide details: _____
19. 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: _____

Location(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 #**	
Location (1)							
Street							
City, State, Zip							
Location (2)							
Street							
City, State, Zip							
Location (3)							
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: _____