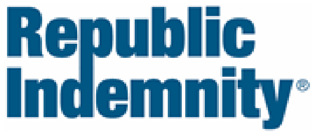


PHYSICIAN'S OFFICES SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

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		**Class**		**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.

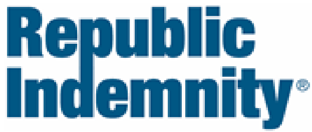
Operational Information

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: __________

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: ____



<u>Location(s) – Please complete for all locations of business operations</u>:

	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

<u>Policy Specifications</u>

Non-Participating Plan Participating

Program: Yes No If yes, Program Name: ____

Commission: ___________% Direct Bill Agency Bill

Producer Authorized Signature: ____ Date: ________________

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.