Republic Indemnity

PHYSICIAN'S OFFICES
SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

Application/Policy #_____

Insured Name: _____ Federal ID #: _____

Effective Date: _____ Web Site: _____ Insurance Email: _____

Agency: _____ Contact: _____

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

	Class: 8834 (CA)/ 8832 (NCCI)				
YEAR					
Current					
1st Prior Yr					
2nd Prior Yr					
3rd Prior Yr					
4th Prior Yr					

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 practice/specialty, please provide details:

   _____

2. Are any of the following services provided: Number of employees involved:_____

Lab Work	Yes ○ No ○	# of FT _____	# of PT _____
Physical or Occupational Therapy	Yes ○ No ○	# of FT _____	# of PT _____
Chiropractics	Yes ○ No ○	# of FT _____	# of PT _____
Urgent Care/Emergency Services	Yes ○ No ○	# of FT _____	# of PT _____
Outpatient Surgery	Yes ○ No ○	# of FT _____	# of PT _____

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 # of employees: Physicians: FT ____ PT ____ Nurse/Med Support: FT____ PT ____ Admin/Clerical: FT ____ PT _____
   Number of temporary/seasonal employees_____
   Number of W2's filed for latest reporting year_____
2. Number of employees: Increasing _____ Decreasing _____ Stable _____
3. Mean wage:
   For mainstream employees in production operations or services offered $_____/hr.
   For administrative staff (e.g. clerical, sales) $_____/hr.
4. Union ○ Non-Union ○ % of employees participating_____
5. 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 ○
6. Group Medical provided: Yes ○ No ○ % of employees participating _____ % of employer contribution _____
   Name of Group Medical Provider: _____

6. Paid Vacation: Yes ○ No ○ Paid Sick Leave: Yes ○ No ○ 401K or Pension: Yes ○ No ○
7. Pre-employment physical: Yes ○ No ○
8. Drug Screening Program/Random Drug Testing: ○ ○
9. Does insured offer modified work: Yes ○ No ○
   *If yes, provide details*_____
10. Loss Control Incentive Program: Yes ○ No ○
11. Percent of Off Premises Operations:_____%
12. Vehicle Exposure: Yes ○ No ○
    #Vehicles_____(comm'l) _____ (private passenger) Radius of Operations _____
    Details of use, include specifics as to delivery exposures:_____
    Number of employees regularly driving: *_____
    *We define regular as over 10% of all production employees time in the aggregate being spent off-premises.
    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: _____
13. What is the maximum manual weight lifted? _____ What material handling aids are used? _____
14. Hours of operation _____
15. Does the applicant own, operate or lease aircraft: Yes ○ No ○
    If yes, provide details_____
16. 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*_____

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

	# Employees assigned to location (including those who work off premises)		# of Shifts	Maximum number of employees on premises at one time	# of Stories/ Floor # occupied by this business	Building Construction Type *(see below)
	Full-time	Part-time				
Location (1) _____ Street _____ City, State, Zip	_____	_____	_____	_____	_____/_____	_____
Location (2) _____ Street _____ City, State, Zip	_____	_____	_____	_____	_____/_____	_____
Location (3) _____ Street _____ City, State, Zip	_____	_____	_____	_____	_____/_____	_____

If more than 3 locations, please continue on separate sheet.

*Types of Building Construction that closely matches the description of building that 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 _____ Program Name: _____

Commission %_____ Direct Bill _____ Agency Bill _____

Producer Authorized Signature _____ Date_____