RESIDENTIAL LIVING CENTERS
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. Applicable only to policy years not insured by Republic Indemnity.

Class:	___________	___________	___________	___________	___________
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. Detailed description of operations, and employees duties:
   ____
   ____
2. Is there any dispensing of medicine? Yes No
3. Number of locations: __________ Average number of residents at each location: __________
4. Maximum Number or percent of ambulatory Residents/Average number of residents at each location: _______________
   ____
   Number or percent of non ambulatory residents: __________
   Number or percent of residents with dementia: __________
   What percent are at a mild level? ________ What percent are at a severe level? ________
   Number or percent of residents with Alzheimer's: __________
   What percent are at a mild level? ________ What percent are at a severe level? ________
   What methods/aids are used for moving patients: ____
5. Are there any programs in place (Sharp, Bloodborne Pathogen, etc.) ? Yes No If yes, please describe details ______
   ____
6. Is there a housing exposure for full-time/part-time/seasonal employees? Yes No
   If yes, is lodging provided to employees expressly in lieu of wages? Yes No
7. Are the owners engaged in day to day operations? Yes No
   Are any family members employed? Yes No
8. Does the insured use volunteers? Yes No
   If yes, how many? _______
   What are their duties? ____
   Is there a seperate volunteer accident policy in place? Yes No
9. Are employees performing any maintenance work? Yes No
   Does the insured sub-contract maintenance work (e.g., roof work, electrical, landscape)? Yes No

General Information

1. Current number of permanent employees for each location: ________
   Employees providing medical, nursing or personal care to residents: ____
   Food service employees: _____________________
   All other employees, salespersons and drivers: ________________________

2. Number of W2's filed for latest reporting year____________________

3. Number of employees: Increasing ________ Decreasing ________ Stable ________

4. Number of part time employees _____________ Number of full time employees _________________

5. Mean wage: For mainstream employees in production operations or services offered $____________/hr.
   For administrative staff (e.g. clerical, sales) $____________/hr.

6. Union Non – Union % of employees participating_________________

7. **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

8. Group Medical provided: 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

9. 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

10. Hiring Practices
    Application: Yes No
    Check References: Yes No

11. Pre-employment physical Yes No

12. Drug Screening Program/Random Drug Testing Yes No

13. Background Checks Yes No

14. Does insured offer modified work: Yes No
    If yes, provide details____

15. Vehicle Exposure: Yes No Radius of Operations ____________________________________
    #Vehicles_______ (comm'l) _______ (private passenger) Types of vehicles: Bus Van Car
    Details of use, including specifics as to delivery exposures, or group transportation exposures if applicable ______________
    ____
    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
    ____

15. Is there any out-of-state travel? Yes No — If yes, who travels? ______________________________________
    Where do they travel? ________________________ — How long do they travel for? ______________________________

16. Does the applicant own, operate or lease aircraft: Yes No
    *If yes, provide details*____

17. 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:

	# 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
Un-reinforced 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_________________

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.