



Submission Checklist

Applicant Name: _____

Effective Date: _____

Mandatory Requirements Needed to Quote

- ❑ Completed/Signed/Dated ACORD Application for Workers Comp.
- ❑ Complete Client List including classification codes associated with each.
- ❑ Completed/Signed/Dated Staffing Lines Supplemental Questionnaire. *If medical placement agency, please complete the Medical Supplemental Addendum as well.*
- ❑ Most current Workers Compensation Experience Modification Worksheet. If no mod available, provide copies of the last 2 completed workers' compensation audits.
- ❑ Loss Runs (valued within 90 days) for current year and three prior years. **Include a detailed description of losses over \$25,000.**
- ❑ Classification Code Referral Form for each class that is ineligible or restricted. Form can be found on our website or email our office for a copy.

Additional Information for Underwriting File

- ❑ Copy of Employment Application.
- ❑ Copy of Employee Time Card (front and back).
- ❑ Copy of contract between insured & temporary worker.
- ❑ Copy of insured's contract with their clients.
- ❑ Copy of Written Safety Material, Training Program, Return to Work Program, etc.
- ❑ If there is no D&B rates for the insured, compiled, audited or reviewed financials are required.
- ❑ Copies of owners' resumes (if in business under 3 years)
- ❑ Sales/Marketing Brochures and Related Company Information



8) Are there established new client selection criteria/procedures? Please provide details on the process.

9) Are job site inspections done on each new client? Explain process and provide copy of form/questionnaire used for inspections.

10) Are procedures in place to terminate clients with poor loss experience or unsafe work environments? Yes No

If yes, please explain: _____

11) Do you have a full-time Safety Director? Yes No

If "Yes", please provide name/title: _____

12) Is the safety director or other employee responsible for the following?

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Job site inspections? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Review Physical Requirements for all job assignments? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Accident Investigation? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claims Review? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are Action Plans developed as claim review result? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are loss control incentives in place? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is Mgmt & Supervisors held accountable for safety? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Additional Duties? _____ |

13) Please check which programs the insured has in place currently.

- | | |
|---|---|
| <input type="checkbox"/> Written Safety Policy | <input type="checkbox"/> Supply Safety Equipment Needed |
| <input type="checkbox"/> Forklift Certification | <input type="checkbox"/> Safety Committee (monthly/quarterly) |
| <input type="checkbox"/> Safe Lift Training | <input type="checkbox"/> Bloodborne Pathogen Training |
| <input type="checkbox"/> Other: _____ | |

14) Does Insured have a written "Return-to-work" program? Yes No

If "Yes", please provide a copy.

If "No", is management willing to implement a program? Yes No

15) Drug testing of applicants is performed (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Prior to Employment | <input type="checkbox"/> After an Accident | <input type="checkbox"/> Only by request of the Client |
|--|--|--|



24) Does the applicant ever have 50 or more employees working at one time at any one client? Yes No If yes, then complete the below matrix.

Client Name	Location	# of EEs	Class Code	Job Description

By signing, we agree that all information included in this supplemental application is accurate at the time of completion and signature.

Producer Name, Date and Signature: _____

Insured Name, Date and Signature: _____



Medical Staffing Supplemental Addendum

Applicant Name: _____

1) Environments in which medical staffing is done (please provide % of payroll for each that apply)

- Hospital, Nursing Home, Psychiatric Facility, Private Homes, Doctor's Office, Dental Office, Prison, Manufacturing Facility, School, Other: _____

2) Percentage of placements in the following occupations:

- RNs, LPNs, CNAs, Lab Techs, Physical Therapists, Pharmacists, Social Workers, Occupational Therapist, Homemaker, Other: _____

3) Does the insured provide traveling nurses? [checkbox] Yes [checkbox] No
Do the employees leave the state insured is headquartered? [checkbox] Yes [checkbox] No
If yes, are all states listed on the accord with payroll? [checkbox] Yes [checkbox] No

4) Does the insured have a written safety program that includes the following?

- OSHA bloodborne pathogens standard? [checkbox] Yes [checkbox] No
Personal Protective Equipment requirements? [checkbox] Yes [checkbox] No
OSHA needlestick safety and prevention? [checkbox] Yes [checkbox] No
Is Hepatitis B vaccine series offered? [checkbox] Yes [checkbox] No

5) Does insured have a written Hazard Communication Policy? [checkbox] Yes [checkbox] No

6) Are employees required to lift or physically transfer patients? [checkbox] Yes [checkbox] No
If so, describe safety training and company procedures for safe lifting:

7) Does insured provide housekeeping personnel to any medical facility? [checkbox] Yes [checkbox] No

8) Please describe eligibility criteria during the employee screening process:

