

WORKER'S COMPENSATION INSURANCE QUESTIONNAIRE

This is not an application but is intended for you to provide the information required for the agent to properly complete and submit an application for you to quote Worker's Compensation coverage.

Applicant Name _____

Mailing Address _____

Business Type Indiv. Partnership Corporation
 Sub S Corp. Other: _____

If a corporation, please provide names and ownership percentages for the President, Secretary & Treasurer _____

Nature of Operations _____

Yrs. In Business _____ Federal Employer ID No. or S.S. # _____

Locations - street address, city, county, state, zip
 1. _____
 2. _____
 3. _____

Desired Effective Date _____

Employer's Liability - Limits Desired

_____ Each Accident
 _____ Disease - Policy Limit
 _____ Disease - Each Employee

Rating Information

Loc.	Class Code	Job Description/Categories	# Employees	Est'd Annual Payroll

Individuals Included/Excluded

(Partners, Officers, Relatives to be included)

Name	DOB	Title/Relationship	Ownership %	Duties	Inc/Excl

Do you offer health insurance to your employees? _____
 If Yes, do you pay at least 50% of the premium for this coverage? _____
 (For employers with at least 2 employees) For additional discount, would you be willing to agree to send all injured workers to a Kaiser facility or preferred provider in your area? _____

Prior Carrier Information: To quote, you must provide 4 years hard copy loss runs and premium amounts from your prior insurer(s) that have been issued in the last 90 days.

Supplemental application: Please also complete and return the attached supplemental information with this form in order to obtain the most favorable quote.

SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

Section 1 – Trade Name (i.e., DBA)

Current: _____

Prior (if applicable): _____

Section 2 – Business Ownership

Legal Name: _____

Legal Entity (check one):

<input type="checkbox"/> 1 Individual (If married, check Husband & Wife)	<input type="checkbox"/> N Non-Profit Organization	<input type="checkbox"/> C Conservatorship
<input type="checkbox"/> 2 Husband & Wife (Both names required in Legal Name.)	<input type="checkbox"/> 3 Joint Venture	<input type="checkbox"/> E Estate
<input type="checkbox"/> 4 General Partnership	<input type="checkbox"/> 8 Public Agency	<input type="checkbox"/> T Trust
<input type="checkbox"/> L Limited Partnership	<input type="checkbox"/> P Incorporated Public Agency	<input type="checkbox"/> S Association
<input type="checkbox"/> 5 Corporation	<input type="checkbox"/> 9 Labor Union	<input type="checkbox"/> J Joint Employer
<input type="checkbox"/> M Non-Profit Corporation	<input type="checkbox"/> U Incorporated Labor Union	<input type="checkbox"/> A Common Ownership
		<input type="checkbox"/> 7 Other:

Section 3 – Licenses

2101 Farm Labor Contractor License: _____

3403 Contractor's State License Board No./Type/Expiration Date: _____

3403 PUC/ICC License Number: _____

3409 Other License Numbers required to do business in CA (please specify): _____

Section 4 – Additional Business Information

2075 Phones: Bus. () Home ()

2075 FAX Number: ()

2075 E-Mail Address: _____

2039 State Employer Identification Number: _____

Section 5 – Social Security Number(s)

2096

Please provide the Social Security Number(s)* for individual owner, husband, wife, corporate officers, or general partners. Attach a separate page if necessary.

(1) Name: _____	*Social Security Number: _____
(2) Name: _____	*Social Security Number: _____
(3) Name: _____	*Social Security Number: _____
(4) Name: _____	*Social Security Number: _____

***DISCLOSURE STATEMENT**

Providing Social Security Numbers is voluntary. If the principals do not wish to provide Social Security Numbers, other acceptable identification shall include: 1) Federal Employer Identification Number (FEIN), 2) State Employer Identification Number (SEIN), 3) Contractor's License or 4) any applicable business license pertinent to the trade or business.

Section 6 – General Information

Do any of the following pertain to the operations of this risk? Please explain all "yes" answers to questions 1-10 in the "Remarks" section on page 2.

	Yes	No		Yes	No
1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press)?			8. Have any locations/operations for which coverage is not requested?		
2. Employ any relatives?			9. Have any operations outside of California?		
3. Employ any minors (under age 18)?			10. Perform any asbestos removal?		
4. Make any cash payments to employees or subcontractors?			11. Member of any trade or business association?		
5. Provide meals or lodging in lieu of wages?			Please indicate: _____		
6. Pay any employees by the piece?					
7. Have any work at a maritime or offshore facility?					

Section 7 – Has the business or any principal of the business declared bankruptcy in the last seven years? Yes No, skip to Section 8

Name of Principal: _____

3103 Chapter of bankruptcy filed (check as applicable): 7 11 13 Other: _____

Date filed: _____ Case Number: _____ Status: pending dismissed discharged

Court where case was filed (Please provide us with a filed, stamped copy of the "Petition for Relief"): _____

Section 8 – Was this operation all or part of an existing business that was purchased or acquired? Yes No, skip to Section 9

What percentage of the business was acquired?: _____ Date ownership changed: _____

Prior business owner's name and address:
 Name: _____
 Address: _____
 Name of Business: _____

Is the prior owner(s) related to the new owner(s)? No Yes, Relationship: _____

Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? No Yes, please explain: _____

Were more than 50% of the current employees hired since the acquisition? Yes No
 Are those new employees earning more than 50% of the payroll? Yes No

Section 9 – Management Practices

Please indicate if you offer: Employee Assistance Program ___ Paid Vacations ___ Paid Sick Leave ___

Do you have a minimum of 2 employees? No Yes

If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) No Yes
 If yes, do you pay at least 50% of the Health Insurance premium? No Yes, Name of Health Insurance Carrier: _____

Please check off the hiring practices implemented by your company: Job Descriptions ___ Pre-placement Medical Screening ___
 Pre-placement Drug Testing ___ Drug-free Workplace ___ Pre-employment Reference Check ___ Union Employees ___

Do you have an Injury and Illness Prevention Program? No Yes

Do you have a written early return-to-work program for employees injured on the job? No Yes

Do you document: Employee Training ___ Facility Inspections ___

Describe your housekeeping: Good ___ Fair ___ Poor ___ Describe the condition of your equipment: Good ___ Fair ___ Poor ___

Have you received any OSHA citations within the past year? No Yes (Please explain in "Remarks.")

Does the business provide temporary employees? No Yes (Please explain in "Remarks.")

Section 10 – Remarks (Attach a separate sheet if necessary.)

Section 11 – Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030 517470
 BROKER ACCESS NUMBER

Cheval Insurance Services, Inc.
 PO Box 2933, Fullerton, CA 92837
 714/447-9191 Fax 714/525-9191
 info@chevalinsurance.com

ADDRESS STATE ZIP
 PHONE NUMBER FAX NUMBER

SIGNATURE

To be completed by the broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge

Name: Holly Lopes Title: Broker
 Please print Please print

Signature: _____ Date: _____
 (FAXed applications must be followed up with original document/signature.)