

Return Completed Form To :

workcomp@kelins.com

or mail to :

**Kelly Insurance Group
700 River Avenue, Suite 433
Pittsburgh, PA 15212**



Kelly Insurance Group, Inc.

EST. 1957

Workers Compensation Supplemental Application

Named Insured: _____		Web Address: _____	
Insured's FEIN: _____			
Contact Name and Phone Number			
Inspections: _____	_____	() -	_____
Premium Audit: _____	_____	() -	_____
Claims: _____	_____	() -	_____
Prior Payroll			
	<u>Total Annual Payroll</u>		
Current Year: _____	_____	_____	_____
Prior Year: _____	_____	_____	_____
Prior Year: _____	_____	_____	_____
Prior Year: _____	_____	_____	_____
Operations and Benefits			
Broker controlled account? <input type="checkbox"/> Yes KELLY INSURANCE GROUP, INC			
Please provide a detailed description of the operation: _____ _____ _____			
Years in business? _____ Hours of operation- _____ to _____			
# of Shifts - _____ Does the applicant ever allow employees to work more than 3 consecutive 12 hour shifts? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is there a driving/delivery exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Radius of operations/travel: <input type="checkbox"/> <50 miles <input type="checkbox"/> 50-100 <input type="checkbox"/> 100+	
If yes, what is frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other: _____		Any group transportation of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a PUC/DMV filing required? <input type="checkbox"/> PUC <input type="checkbox"/> DMV <input type="checkbox"/> N/A		If yes, how provided? <input type="checkbox"/> car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus	
Are vehicles company owned? <input type="checkbox"/> Yes <input type="checkbox"/> No		# of employees transported per vehicle _____	
If yes, types of vehicles: _____		# of vehicles used to transport _____	
If yes, are vehicles taken home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
# Of vehicles? _____ # Of drivers? _____			
Vehicle/fleet maintenance program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, who does the servicing? <input type="checkbox"/> Outside vendor <input type="checkbox"/> In-house mechanics <input type="checkbox"/> Other: _____			
Do employees use personal vehicles for company business? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do any employees work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any out of state, international or overnight (within state) travel? <input type="checkbox"/> Yes <input type="checkbox"/> No		List the # of employees who live or work out of state:	
If yes, please provide details -		_____ Live _____ Work	
Why/purpose? _____			
Who will travel? _____			
Where? _____			
Duration? _____			
Frequency? _____			
# of employees: Full time _____ Part-time _____ Seasonal _____ Volunteers _____ (Verify number is consistent with the number on Acord App)			
# of employees per location: #1 _____ #2 _____ #3 _____ #4 _____ (If more space is needed please use separate page)			
# of W-2's issued – Last year _____ Previous year _____		How are employees paid? <input type="checkbox"/> Hourly	
Any day laborers or temporary/employee leasing? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Piece rate <input type="checkbox"/> Commission <input type="checkbox"/> Flat salary	
If yes, please provide details on separate page.		<input type="checkbox"/> Other: _____	
% of union employees _____ % of non-union _____ If union, Exp. date of contract _____		Paid Sick Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Actual average hourly wage for employees in governing class \$ _____/hour		Paid Vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Retirement / Pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does employer contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group medical provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		% of employees enrolled _____	
If yes, name of healthcare provider - _____		% paid by employer _____	
Do you use a specific medical provider to treat injured employees? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you currently participating in a MPN (Medical Provider Network)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the name of current MPN: _____			
CPR training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		RTW Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
# of employees certified? _____		Does it include salary continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the ownership of the applicable entity changed within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details: _____			

Hiring Practices – Employee Selection - Claims

Written Application?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-hire drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reference Checks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Post Accident drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre/post employment Physicals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	MVR Checks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic back testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Audio hearing tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formal job descriptions on file?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Criminal Background Checks ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are personnel files documented for pre-existing injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a formal written accident report? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Average claim reporting time frame - _____		Are there set procedures for reporting claims? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is job specific training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Any Interchange of labor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee Orientation Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain <input type="checkbox"/> Another business <input type="checkbox"/> Subsidiary	
If yes, is the orientation <input type="checkbox"/> Verbal only? <input type="checkbox"/> Verbal and Documented?		<input type="checkbox"/> between departments <input type="checkbox"/> Other: _____	
Employee to Supervisor ratio - <input type="checkbox"/> Better than 4-1 <input type="checkbox"/> 5-1 <input type="checkbox"/> 6-1 <input type="checkbox"/> 7-1 <input type="checkbox"/> >7-1			
Subcontractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____			
If yes, are certificates of insurance obtained and kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Independent contractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____			
If yes, how are they paid? <input type="checkbox"/> 1099's? <input type="checkbox"/> Other? Please explain- _____			

Safety Program and Organization – Work premises and Environment

Are owners active in daily operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are they excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Active injury & illness prevention program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has loss control services been performed in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Active safety incentive program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has Cal/OSHA visited or cited your business in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does it encompass all employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide explanation on separate page.
What type of incentive? _____		Are safety meetings conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do employees receive safety training/orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
If yes, is the training - <input type="checkbox"/> Formal / Documented <input type="checkbox"/> Informal		<input type="checkbox"/> Other: _____
Do you have a safety director or risk manager? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and title: _____	
If yes, is the position full time or an additional responsibility of another employee? _____		
MSDS (Material Safety Data Sheets) available for all chemicals and products used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Any material handling exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____		
Any lifting exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Forklift training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
If yes, <input type="checkbox"/> <25 lbs. <input type="checkbox"/> 25-40 <input type="checkbox"/> 40+	If yes, annual certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If 40+, manual lifting or with assistance? Please explain _____		
Is all machinery/equipment properly guarded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Any use of Baler equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Written Lock out / tag out / block out procedures in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Condition of equipment? <input type="checkbox"/> New <input checked="" type="checkbox"/> Good <input type="checkbox"/> Average	
Respiratory program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Are all equipment operators trained/ certified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
What is the maximum height at which you will work? _____	Personal protection equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
What is used? <input type="checkbox"/> Ladder <input type="checkbox"/> Scaffolding <input type="checkbox"/> Scissor lifts <input type="checkbox"/> N/A	If yes, strict enforcement of utilization? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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If scaffolding used, does the insured build their own? <input type="checkbox"/> Yes <input type="checkbox"/> No	What types of PPE? _____
Is the building / premises - <input type="checkbox"/> Owned or <input type="checkbox"/> Leased?	# Of years at current location? _____
Condition of premises? <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Average	Age of building occupied? _____ year(s)

Agriculture - Farming

Is harvesting mechanized or manual? _____	
Do you use contracted labor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is housing provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, % of use? _____	If yes, # of employees housed - _____
Any seasonal workers used for operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does all farm machinery have safety guards intact? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details of when season begins and ends, # of seasonal employees hired, and if same employees used each season	
Are employees transported by any vehicles on or off the premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain on separate page.	
Any use of pesticides or fertilizers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any crop dusting operations? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, applications by <input type="checkbox"/> Employees? <input type="checkbox"/> Outside Vendor?	If yes, services provided by <input type="checkbox"/> Employees? <input type="checkbox"/> Outside Vendor?
Do any family members work in operation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any work off premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain on separate page.

Dairy Farms:

What is the size of dairy herd? _____	Number of Bulls over 3 years old? _____
Does risk grow their own feed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does risk deliver any of their own milk products? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is milking barn - <input type="checkbox"/> Flat? <input type="checkbox"/> Elevated?	Protective Barriers? <input type="checkbox"/> Yes <input type="checkbox"/> No
Average number of milkings per day? _____	Do any employees conduct or complete work on sump pumps? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are employees allowed to enter stem pipes around lagoon? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are proper safety procedures in place for working near stem pipes, lagoons or sump pumps? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any confined spaces exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on separate page - include copy of written procedures and details of Confined Spaces Training.	

Automotive Services

Any towing services provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any road repair assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, any contract towing? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, 24 hour exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a mini-market on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any fueling operations? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, any sales of Alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any security/surveillance cameras on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
Open 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any test driving of customers' vehicles? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is cashier's booth bullet proof? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any transportation of customers? <input type="checkbox"/> Yes <input type="checkbox"/> No
Access to Freeway? <input type="checkbox"/> 0-1 mile <input type="checkbox"/> 1-2 miles <input type="checkbox"/> 2+ miles	
Any off-premises or mobile services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details including percentage of payroll dedicated: _____	
Any vehicle crushing operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a ventilated/filtered spray booth for painting operations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Do you have a written respiratory protection program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
If yes, do employees complete a medical evaluation questionnaire? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If medical evaluation questionnaire completed, is it reviewed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are employees properly trained in the use and care of respiratory protection equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Has proper fit testing been provided to each employee and their assigned respirator? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any work performed on vehicles greater than 2.5 ton capacity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are employees ASE trained and certified? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many employees? _____	

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Contractors

Contractors license number? _____		Years experience in trade? _____	
Estimated annual gross sales? _____		Estimated # of jobs per year? _____	
Percentage of work sub-contracted out? ___ % What type? _____			
If subs used, does insured: <input type="checkbox"/> Check annually? <input type="checkbox"/> Directly supervise subs?			
Average # of certificates collected annually? _____		Average # of Waivers of Subrogation needed? _____	
Indicate % of work conducted in each of the following operations (must equal 100% for each):			
1) New Construction ___	Remodeling ___	Service/Repair ___	
2) Commercial ___	Apts/Condos/Tract Homes ___	Single Custom Homes ___	
3) Interior ___	Exterior ___ If exterior work done, what is the maximum height exposure? _____		
Any use of cranes, booms or similar heavy construction equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Any work below grade? <input type="checkbox"/> Yes <input type="checkbox"/> No	Max Depth in feet - _____	% of total work - _____	
Any confined spaces exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on separate page – include copy of written procedures and details of Confined Spaces Training.			
Any work involving asbestos, hazardous product abatement, chemical/petroleum products, USL&H, underground tank or pipe replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain - _____			
Does this risk conduct work for the government or city municipality? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the applicant involved in "Wrap Up" or "OCIP" projects <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide percentage of total payroll dedicated to these projects, and advise detailed procedures on how applicant determines employee split between these projects and other contracts/projects (not Involving "wrap up" or "OCIP".			
Indicate % of work conducted in each of the following operations or Mark not applicable - <input type="checkbox"/> N/A			
Blasting _____	Drilling _____	Light Pole Work _____	Demolition _____
Grading _____	Wrecking _____	Multi Story Buildings _____	Gas Mains _____
Asbestos _____	Highway Work _____	Scaffold set-up _____	Roofing _____
Sewer _____	Exterior Framing _____	Structural Steel _____	Bridge Work _____
Supervisory only _____	Street/road work _____	Spray painting _____	Dock/Sea Walls _____
Tunneling _____	Crane Work _____	Concrete Tilt-up _____	Excavation _____

Apartment Ops / Building Ops / Hotel/Motel

Is housing provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any furnished apartments available? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, # of employees housed and describe their responsibilities: _____	If yes, % of units furnished? _____ %
Are employees involved in property maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide details: _____	
Security Guards employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Security cameras or other security devices on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide details (i.e. armed or unarmed, hours on premises): _____	
Does management collect payment from resident and/or is banking controlled by employee(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are employees responsible for eviction notification and/or enforcement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of guest rooms? _____	Room rates: <input type="checkbox"/> <\$50 <input type="checkbox"/> \$50-\$100 <input type="checkbox"/> \$100+ Rent rooms - <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Any shuttle, limo or similar service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain - _____	
Any Restaurant exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does it include 24 hour room service? <input type="checkbox"/> Yes <input type="checkbox"/> No Bar or Lounge Area? <input type="checkbox"/> Yes <input type="checkbox"/> No
Any entertainment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain - _____	
Housekeeping exposures: Moving of furniture? <input type="checkbox"/> Yes <input type="checkbox"/> No Mattress flipping or rotating? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how often and # of employees involved in process? _____	

Janitorial Contractors

Check appropriate exposures in the following areas:		<input type="checkbox"/> Education Facilities	<input type="checkbox"/> Nursing Homes	<input type="checkbox"/> Apartment houses
<input type="checkbox"/> Hospitals	<input type="checkbox"/> Airports	<input type="checkbox"/> Office Buildings	<input type="checkbox"/> Stores	<input type="checkbox"/> Fire/Flood/Restoration
<input type="checkbox"/> Government	<input type="checkbox"/> Museums	<input type="checkbox"/> Medical Offices	<input type="checkbox"/> Hotels	<input type="checkbox"/> Manufacturing Plants

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Indicate % of services provided (must equal 100%):			
___ General cleaning*	___ Chimney cleaning	___ Debris Clearing	___ Exterior window cleaning above 1 st floor
___ Industrial cleaning	___ Ceiling Tile cleaning	___ landscaping	___ Heating, A/C ventilation service
___ Carpet Cleaning	___ Elevator maintenance	___ Parking lot cleaning	___ Aircraft service and maintenance
___ Snow removal	___ Maid/housekeeping services	___ Fire/flood restoration	___ Servicing/cleaning of hoods/filters/grease traps/etc
___ Pest control	___ Floor waxing and refinishing	___ Crime scene clean-up	___ Pressure or steam washing operations
* General Cleaning includes operations such as vacuuming, dusting, wastebasket trash pick up, floor and rug cleaning, restroom clean-up			
Do employees work in pairs or more? <input type="checkbox"/> Yes <input type="checkbox"/> No Employees supervised? <input type="checkbox"/> Yes <input type="checkbox"/> No Direct or Roving supervision? _____			
Landscaping			
Any tree trimming performed that is off the ground?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any boulder or tree removal performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any use of tractors, loaders or similar equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any highway or median work conducted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any use of chippers, mulchers, cherry pickers, booms or other similar equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain - _____			
Any use of pesticides or fertilizers? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, is the application completed by - <input type="checkbox"/> Employee? <input type="checkbox"/> Outside Vendor?			
Any debris removal or land clearing activities? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain - _____			
Manufacturing – Machine Shops			
Any punch press or press brake machinery/equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Machine Guarded:	<input type="checkbox"/> Point of operation <input type="checkbox"/> Drive Mechanism
Age of machinery: <input type="checkbox"/> <2 yrs <input type="checkbox"/> 2-5 yrs <input type="checkbox"/> 5-10 yrs <input type="checkbox"/> 10+ yrs	Accessible moving parts guarded on machinery/equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Types of machines (must equal 100%) - Heavy ___ Mid ___ Light ___		Any Computer Network Controlled (CNC) machinery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
% of off-premise operations: ___ If yes, where/what for? _____			
Is building properly ventilated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is proper dust collection system in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Restaurants			
Entertainment provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bar or separate lounge area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fast Food?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any catering?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of: ___ Hosts ___ Waitpersons ___ Bartenders	If yes, radius of operations: ___ miles % of exposure - ___		
___ Valet ___ Busboys ___ Cooks	Any delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No Delivery hours - ___ to ___		
Average price of entrée? <input type="checkbox"/> <\$5 <input type="checkbox"/> \$5-\$15 <input type="checkbox"/> \$15+	If yes, radius of operations: ___ miles % of exposure - ___		
Servicing, cleaning of hoods/filters/grease traps or related systems provided by: <input type="checkbox"/> Outside vendor <input type="checkbox"/> Employees			
Retail / Wholesale			
Type of Merchandise? _____			
Gross Receipts: Wholesale ___ % Retail ___ % Warehousing? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Any repacking or repackaging operations? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain operations: _____			
Assembly exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain exposure: _____			
Any distribution exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by common carrier or does insured have a trucking exposure? Please explain on separate page.			
Trucking			
Type of Authority: a) <input type="checkbox"/> Common Carrier <input type="checkbox"/> Contract Carrier <input type="checkbox"/> Private <input type="checkbox"/> Brokerage <input type="checkbox"/> Exempt			
b) <input type="checkbox"/> Regular Route <input type="checkbox"/> Irregular Route			
Carrier Operations: <input type="checkbox"/> California Only <input type="checkbox"/> Interstate			
Length of Haul with Total % = 100%:			
Under 50 Miles ___ %	50 – 200 ___ %	201 – 300 ___ %	
301 – 500 ___ %	501 – 1,000 ___ %	Over 1,000 ___ %	
Filings: DOT# ___ PUC# ___ DMV/MCP# ___ <input type="checkbox"/> Not Applicable			
Please Check the Questions and Attached the Applicable Data:			
Motor Carrier Identification Report, MCS-150: <input type="checkbox"/> Attached or <input type="checkbox"/> Not Applicable			

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Cargo Classification: See attached MCS-150 or See below (check all that apply):

<input type="checkbox"/> General Freight	<input type="checkbox"/> Logs, Poles Beams, Lumber	<input type="checkbox"/> Liquids/Gases	<input type="checkbox"/> Grain, Feed, Hay	<input type="checkbox"/> Chemicals
<input type="checkbox"/> Household Goods	<input type="checkbox"/> Building Materials	<input type="checkbox"/> Intermodal Containers	<input type="checkbox"/> Coal, Coke	<input type="checkbox"/> Commodities Dry Bullion
<input type="checkbox"/> Metal Sheets, Coils, Rolls	<input type="checkbox"/> Mobile Homes	<input type="checkbox"/> Passengers	<input type="checkbox"/> Meat	<input type="checkbox"/> Refrigerated Food
<input type="checkbox"/> Motor Vehicles	<input type="checkbox"/> Machinery, Large Objects	<input type="checkbox"/> Oilfield Equipment	<input type="checkbox"/> Garbage, Refuse, Trash	<input type="checkbox"/> Beverages
<input type="checkbox"/> Driveway/Towaway	<input type="checkbox"/> Fresh Produce	<input type="checkbox"/> Livestock	<input type="checkbox"/> U.S. Mail	<input type="checkbox"/> Paper Products
<input type="checkbox"/> Other _____				

Drivers: a) Number of Drivers _____ b) Number of Owner/Operators used _____

- Percentage where the Motor Carrier will provide workers' compensation for the Owner/Operators _____ %

- Percentage where the Motor Carrier will agree with the Owner/Operator that the Owner/Operator assumes the responsibilities of an Employer for the performance of work: _____ %

c) If Owner/Operators used, please attach copy of contract: Attached or Not Applicable

d) Number of company drivers with Motor Carrier at least 12 months: _____

Number of Owner/Operator with Motor Carrier at least 12 months: _____ or Not Applicable

e) Number of Non-Union: _____ Union: _____

f) Do the drivers load and unload their trucks? No Yes (please provide detail of the types of materials loaded/unloaded and any equipment used: _____)

Is the applicant enrolled in the DMV Pull Program? Yes No If so, how often? _____

Is the applicant enrolled in the CHP BIT Program? Yes No

Total # of Trucks _____ # of Trucks with Sleeper Cabs _____ Single Trailers _____ Double Trailers _____ Triple Trailers _____

Any trucks / trailers with ramps? Yes No If yes, please provide # _____

Any trucks / trailers with lift-gates? Yes No If yes, please provide # _____

Any team driver operations? Yes No If yes, please provide details- _____

If union operations, provide Month / Year of contract renewal: _____

Public Entities

Municipality _____ County _____

Check each applicable operational department / category:

<input type="checkbox"/> Water Department	<input type="checkbox"/> Power Department	<input type="checkbox"/> Sewer Department	<input type="checkbox"/> Street / Road Department
<input type="checkbox"/> Street Sweeping / Cleaning	<input type="checkbox"/> Building Inspector	<input type="checkbox"/> Code Enforcement	<input type="checkbox"/> Garbage / Refuse / Recycling
<input type="checkbox"/> Parks / Recreation	<input type="checkbox"/> Landscape Maintenance	<input type="checkbox"/> Tree Trimming	<input type="checkbox"/> Waste Treatment
<input type="checkbox"/> Housing Authority	<input type="checkbox"/> Day Care / Child Care	<input type="checkbox"/> Public Housing Nurse	<input type="checkbox"/> Electricians
<input type="checkbox"/> Painters	<input type="checkbox"/> Mechanic	<input type="checkbox"/> Truck Driver	
<input type="checkbox"/> Fire Department	<input type="checkbox"/> Police Department	<input type="checkbox"/> Animal Control	

F/T Staff _____ # P/T Staff _____

Any Volunteers or Intern Staff? Yes No If yes, explain _____

City Council Positions? Yes No # _____

County Supervisors Positions? Yes No # _____

Does the hiring process include: Drug Screening? Yes No Pre Employment Physicals? Yes No If yes, explain _____

Any Post Accident Drug Testing? Yes No

Is there a probationary period upon hire? Yes No If yes, explain _____

Are employees provided with any New Employee Orientation? Yes No

Does each job have a written job description? Yes No

Do employees receive initial job training? Yes No

Is training on-going and documented? Yes No

Do employees work shifts? Yes No If yes, explain _____

Any on-call employees? Yes No If yes, explain _____

Do any employees have take home vehicles? Yes No If yes, explain _____

Any underground work? Yes No If yes, explain _____

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workcomp@kelins.com or mail to :

Kelly Insurance Group

700 River Avenue, Suite 433Pittsburgh, PA 15212

Workers Compensation Supplemental Application

Any work above 12' in height? Yes No If yes, explain _____

Any confined space exposures? Yes No If yes, explain _____

If yes, is there a Written Confined Space Entry Program? Yes No

Any sub-contracted operations? Yes No If yes, explain _____

Are W / C Certificates of Insurance obtained on all sub-contractors? Yes No

Any use of independent contractors? Yes No If yes, explain _____

Number of vehicles? _____ Driving Radius? _____

Do employees use personal vehicle for business purposes? Yes No If yes, explain _____

Newspaper / Publishing

Any home delivery services? Yes No If yes, independent contractors and/or employees? _____

Provide details: _____

Any delivery operations? Yes No If yes, # of vehicles _____ Driving radius _____

Any telemarketing operations? Yes No If yes, independent contractors and/or employees? _____

Provide details: _____

Any security operations? Yes No If yes, independent contractors and/or employees? _____ Armed or Unarmed? _____

Provide details: _____

Do employees or independent contractors use personal vehicle for company business? Yes No

If yes, are certificates of insurance in file? Yes No

Are MVR's (Motor Vehicle Reports) obtained on all drivers? Yes No Is the Company enrolled in the DMV "Pull" Program? Yes No

Any employee or independent contractor travel: Out of State, Out of Country, On Navigable Waters, within War Zones or Exposure to Civil Disturbances, Etc.? Yes No If yes, provide details: _____

Any excessive noise levels within the operations? Yes No If yes, provide details: _____

Have noise levels been evaluated within the Press / Bindery Areas and/r areas with noise producing machinery and equipment? Yes No

If yes, provide details: _____

If noise level testing has been completed, are copies of the results available for review? Yes No

Does the company have a written Hearing Conservation Program? Yes No

Do employees use/wear and PPE (Personal Protective Equipment)? Yes No If yes, provide details: _____

Does the company have a written Ergonomics Program? Yes No

Does the company have a written Material Handling Program, with identified weight limits? Yes No

Does the company have a written Lock Out / Tag Out Program? Yes No

Is maintenance of equipment / machinery completed by employees and/or outside vendors? Yes No If yes, provide details: _____

Are all forklift / material handling equipment operations certified? Yes No

Pest Control

Type of operations: Commercial Agricultural Residential Industrial Structural

Structural repairs or replacements Dry Rot Wood Repair Shower Pan Replacement

Chemical Treatment Services Fumigation Foam Other

Provide Details: _____

Percentage of tenting, if any? _____

Lawn treatment or care? Yes No If yes, provide details: _____

Other Service _____

Provide details: _____

Place an (x) next to each of the applicable services available:

<input type="checkbox"/> Ants	<input type="checkbox"/> Spiders	<input type="checkbox"/> Roaches	<input type="checkbox"/> Fleas	<input type="checkbox"/> Ticks	<input type="checkbox"/> Wasps
<input type="checkbox"/> Mosquitoes	<input type="checkbox"/> Bees	<input type="checkbox"/> Killer Bees	<input type="checkbox"/> Bee Removal	<input type="checkbox"/> Mice	<input type="checkbox"/> Termite
<input type="checkbox"/> Rats	<input type="checkbox"/> Snakes	<input type="checkbox"/> Raccoons	<input type="checkbox"/> Opossum	<input type="checkbox"/> Skunks	<input type="checkbox"/> Bats
<input type="checkbox"/> Rodents	<input type="checkbox"/> Gopher Control	<input type="checkbox"/> Bird/Pigeon Control	<input type="checkbox"/> Animal Trapping	<input type="checkbox"/> Animal Removal	<input type="checkbox"/> Bird/Rodent Proofing

Other If other, provide details: _____

Personal protective equipment required: _____

Workers Compensation Supplemental Application

Written Injury & Illness Prevention Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Written Haz-Com Program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Written Heat Stress Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Written Respiratory Protection Program? <input type="checkbox"/> Yes <input type="checkbox"/> No
Written Fall Protection Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Special Written Procedures for working in Confined Spaces (Attics & Under Residences / Buildings)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Documented New Employee Orientation including Documented Training? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Healthcare

<input type="checkbox"/> For Profit	<input type="checkbox"/> Hospital Affiliation _____
<input type="checkbox"/> Not For Profit	<input type="checkbox"/> Religious Affiliation _____
<input type="checkbox"/> Medicare Certified	<input type="checkbox"/> JCAHO Accredited (Date) _____
<input type="checkbox"/> Medicaid Certified	<input type="checkbox"/> Government
	% of Total Residents Separate Unit ?
Psychiatric Care(excluding depression)	_____ % _____
Dementia/Alzheimer	_____ % _____
Mental Retardation	_____ % _____
HIV (Aids)	_____ % _____
Other: _____	
% of Ambulatory without assistance _____	
Please explain any changes during the last 3 years; Or anticipated changes in the next year. _____	
Does your IIPP (SB198) address the following specific Healthcare related exposures:	
Patient Handling ?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment: _____
Blood-borne Pathogens ?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment: _____
Aggressive/Combative Behavior ?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment: _____
Any other ?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment: _____
Is a Registered Nurse, Manager or supervisor who knows procedures for Workers' Compensation and Safety on each shift ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you treat any worker injuries on site ?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Describe _____
Are all injuries reported to your insurer ?	<input type="checkbox"/> Yes <input type="checkbox"/> No, Explain _____
Do you have a policy to maintain contact with an injured worker ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Skilled Nursing Facilities only, Please answer the following:	
Within the past year has their been a change in the Administrator or Director of Nursing positions ? <input type="checkbox"/> No <input type="checkbox"/> Yes, Explain _____	

% turnover of RN/LVN positions during the past year ? _____	
What % of new residents do you evaluate prior to admission ? _____	

Note: All information provided is subject to verification by way of an underwriting survey or inspection. We must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Signature of Applicant: _____ Date: _____

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