

# Supplemental Workers Compensation Application

**Named Insured:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Producer Agency Name:** \_\_\_\_\_

**Payroll Deduction Company Name:** \_\_\_\_\_

**Employee Benefits:**

Medical Insurance provided?  Yes  No \_\_\_\_\_

Percent Paid by Employer: \_\_\_\_\_ % **Company FEIN:** \_\_\_\_\_

**PreHire Screening:**

Drug Test:  Yes  No \_\_\_\_\_

Post Accident:  Yes  No \_\_\_\_\_

PreHire:  Yes  No \_\_\_\_\_

Random:  Yes  No \_\_\_\_\_

**Safety Program:**

Written?  Yes  No \_\_\_\_\_

Meetings?  Yes  No \_\_\_\_\_

How Often? \_\_\_\_\_

Minutes Kept?  Yes  No \_\_\_\_\_

Describe personal protective equip. (if any) \_\_\_\_\_

Describe housekeeping/premises condition/procedures \_\_\_\_\_

**Accident Investigation Program:**

Who does? \_\_\_\_\_

Records Maintained? \_\_\_\_\_

**Vehicles and Equipment:**

Any company owned vehicles? \_\_\_\_\_

Transportation of Employees? \_\_\_\_\_

Delivery? \_\_\_\_\_ Radius? \_\_\_\_\_ Driver MVR's checked? \_\_\_\_\_

Any scaffolding installed / used by insured? \_\_\_\_\_ Max height \_\_\_\_\_

Describe machine guarding: \_\_\_\_\_ Lock-out/tag out procedure? Yes No

**Use of Sub-contractors:**

Any used? \_\_\_\_\_

Certificates required?  Yes  No \_\_\_\_\_

Hold Harmless?  Yes  No \_\_\_\_\_

**Designated Medical Provider:**

Who is the designated Medical Provider? \_\_\_\_\_

Will you use American Liberty's?  Yes  No \_\_\_\_\_

**Transitional Duty Program:**

Do you have one?  Yes  No \_\_\_\_\_

Is it required?  Yes  No \_\_\_\_\_

**REMARKS:** \_\_\_\_\_

**Insured Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Producers Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_