Travelers Workers' Compensation Supplemental Application

(Attach prior 4 years loss runs please.)

Named Insured ______________________ Effective Date ______________

Mailing Address ______________________________________

Location Address ______________________________________

Location Address ______________________________________

Years in Business ____________ Legal Entity ______________________

FEIN ____________ State ID ____________ NCCI ID ______________

Experience Modification Factor ____________

Limits Each Accident/Disease – Policy Limit / Disease – Each Employee				
Location #	Class Code /Category	Number of **Full Time** Employees	Number of **Part Time** Employees	Estimated Annual Remuneration

Officer / Partner Exclusions

Officer/Partner Name and Title ______________________________________

Officer/Partner Name and Title ______________________________________

Officer/Partner Name and Title ______________________________________

Officer/Partner Name and Title ______________________________________

Carrier / Premium / Loss Info							
Year	Co	Annual Premium	Mod	# Claims	Amt Paid	Reserve	Policy #

Inspection / Claim Kit Contact Person's Name

Name ______________________________________

Phone ______________________ Email Address ______________________

SIGNATURE ______________________________ **DATE** ______________

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Named Insured ______________________________ Effective Date ____________________

FEIN ________________

1. Total Number of Employees: ______ Full Time: ______ Part Time: ______ Temporary: ______
2. Is it a union shop? ☐ Yes ☐ No
3. Number of employees is or has been ☐ Increasing ☐ Decreasing ☐ Stable
4. Is group medical provided? ☐ Yes ☐ No Number of Employees participating _____
5. Employer designated clinic for industrial injury? ☐ Yes ☐ No
6. Are there pre-employment physicals? ☐ Yes ☐ No
7. Are employment references checked? ☐ Yes ☐ No
8. Is pre-employment drug screening performed? ☐ Yes ☐ No
9. Return to light duty plan? ☐ Yes ☐ No With full pay? ☐ Yes ☐ No
10. Is there a return to full time modified work plan? ☐ Yes ☐ No
11. Is there a formal safety program per SB198? ☐ Yes ☐ No
12. What does it consist of? ____

    ____
13. Is there a safety coordinator? ☐ Yes ☐ No Name of individual________________
14. Are safety meetings conducted? ☐ Yes ☐ No How often ?______________
15. Is there any unique safety measures in place? If so please specify______________________

    ____
16. Is there an incentive program in place? ☐ Yes ☐ No
17. What types of job training are in place? ____

    ____
18. Is the insured maintaining their facilities and equipment? ☐ Yes ☐ No
19. How often? ____
20. How does the insured address housekeeping, industrial hygiene & ergonomics issues?

    ____
21. Are all machines equipped with safety guards? ☐ Yes ☐ No
22. Is there an aircraft or watercraft exposure? ☐ Yes ☐ No
23. Is there any athletic sponsorship? ☐ Yes ☐ No
24. Do employees drive their vehicles on the job? ☐ Yes ☐ No
25. Does the insured run MVR's? ☐ Yes ☐ No

SIGNATURE ______________________________ **DATE** ____________________