PMC Insurance Group
A National Workers' Compensation Wholesaler

www.pmcinsurance.com

# Supplemental WC Application –Health Care

**Instructions:**

- Please type or print clearly in ink. All sections must be completed fully.
- If you need more space, attach additional sheets as needed using company letterhead

## 1. APPLICANT OVERVIEW

Firm Name: _____
(If the insured has a DBA please list)

Does Common ownership (over 50%) exist with any other operation? ❒ Yes ❒ No

If "yes", give names and types of operations managed and owned:

_____

List the Applicants State of Operation: _____
❒ For Profit ❒ Not for Profit ❒ Partnership ❒ Other (specify): _____

Date business established: _____ Number of years under current ownership: _____

Payroll History Current_____2nd Year_____3rd Year_____4th Year_____5th Year_____

Website URL is: www._____

a) Are medical/health insurance benefits provided to employees? ❒ Yes ❒ No
b) Current number of: Total # of W-2 Employees _____ Full Time Employees _____ Part Time Employees _____
c) Indicate annual turnover rate: _____%
e) Are at least 51% of the applicant's staff "professional" employees? ❒ Yes ❒ No
f) What is the average wage for employees in the governing class? $_____ Is 24 hour staffing provided ❒ Yes ❒ No
h) Indicate percentage of volunteers in the workforce: ❒ 0% ❒ 1 – 10% ❒ 11 – 40% ❒ > 40%
i) Does the Applicant have a skilled Nursing facility ❒ Yes ❒ No

## **Business Operations** (check all that apply)

❒ Home Health - Skilled Nursing
❒ Personal Care Provider
❒ Hospice Provider
❒ Physical Therapy / Occ. Health
❒ Substance Abuse Counseling
❒ Mental Health Counseling
❒ Crisis Response Team
❒ Drug Treatment / Detox
❒ Nursing Home
❒ Assisted Living
❒ Community Hospital
❒ Clinic

Please indicate where your employees perform their work:

❒ Private Homes/Apt. _____%
❒ Doctor's offices _____%
❒ Day Care Setting _____%
❒ Clinics _____%
❒ Hospitals _____%
❒ Community Residences _____%
❒ Nursing Homes _____%
❒ Corporate offices _____%
❒ Other Locations _____%

Please specify if other:

_____

_____

# Supplemental WC Application – Home Health Care
**PMC Insurance Group**

## 2. RISK MANAGEMENT AND SAFETY PROGRAMS

a) Are independent contractors required to carry their own workers' compensation insurance? ❒ Yes ❒ No
b) How many independent contractors are being used? _____
c) What are the duties of the independent contractors?_____
d) Are independent contractors medical licenses checked annually? ❒ Yes ❒ No
e) Are copies of the insurance certificates obtained annually and kept on file? ❒ Yes ❒ No
f) Do employees drive personal or company vehicles to and from clients during the workday? ❒ Yes ❒ No
g) What is the average radius that employees drive during the work day? _____ miles
h) Are Motor Vehicle Records (MVR) checked annually for all employees and/or Independent Contractors who drive as part of their job? ❒ Yes ❒ No
i) Is a formal safety program in place? ❒ Yes ❒ No
j) If a formal safety program is in effect, please indicate applicable elements:

❒ Driver Safety Programs ❒ Accident/Injury Investigation ❒ New Employee Orientation
❒ Safety Committee ❒ Patient Handling/Transfer Training ❒ Blood Borne Pathogen
❒ Safety Incentive Program ❒ Performance Evaluations include safety ❒ Combative Patient Training
❒ Regular Formal Safety Training Conducted
❒ Management involvement in safety (describe below if checked)

_____

**Hiring Practices:**

Check the following boxes to indicate screening measures that are applied to prospective employees (note: some are post offer)

❒ Reference Check ❒ Validate Work History ❒ Personal Interviews
❒ Drug Testing/Screening ❒ Criminal Background Check ❒ Verification of Certifications/Licenses
❒ Post-Offer Physicals ❒ Child Abuse Clearance ❒ Psychological Testing

**Claims Management:**

a) Is there a designated person to manage workers' compensation claims? ❒ Yes ❒ No
b) Is there a formal Return to Work/Modified Duty Program in place? ❒ Yes ❒ No
c) Have detailed light duty job descriptions been developed? ❒ Yes ❒ No
d) Has a relationship been established with a preferred medical provider/facility ❒ Yes ❒ No

## 3. INSURANCE INFORMATION

a) Has the applicant had continuous WC coverage for the past 2 years? ❒ Yes ❒ No
b) Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years? ❒ Yes ❒ No
c) Has the applicant's WC been cancelled for Underwriting Reasons, other than carrier appetite change? ❒ Yes ❒ No
d) Is the applicant's current WC insurance provided through an Assigned Risk Plan? ❒ Yes ❒ No
e) Does the applicant supply any workers to other employers on a temporary or permanent basis? ❒ Yes ❒ No
f) Are all the applicant's operations (exclusive of monopolistic states) being submitted? ❒ Yes ❒ No

***This information is accurate and complete to the best of my knowledge and represents the operations and exposures of the above noted applicant.***

Applicant Name (printed): _____ Signature: _____

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