PMC Insurance Group
A National Workers' Compensation Wholesaler

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Supplemental WC Application – Health Care

I. 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", please provide names and types of operations managed and owned: _____

_____

_____

List the applicant's state of operation: _____

☐ For Profit ☐ Not for Profit ☐ Partnership ☐ Other (specify): _____

Payroll History
Current: _____
2nd Year: _____
3rd Year: _____
4th Year: _____
5th Year: _____

Indicate annual turnover rate: _____

Are at least 51% of the applicant's staff "professional" employees? ☐ Yes ☐ No

What is the average wage for employees in the governing class ($): _____

Is 24-hour staffing provided? ☐ Yes ☐ No

Are there shifts over 10 hours? ☐ Yes ☐ No

Indicate percentage of volunteers in the workforce: ☐ 0% ☐ 1-10% ☐ 11-40% ☐ >40%

Does the applicant have a skilled nursing facility? ☐ Yes ☐ No

Are crime statistics reviewed prior to sending employees to a residential location? ☐ Yes ☐ No

Is the applicant part of a public or government agency? ☐ Yes ☐ No

Business Operations (check all that apply)

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

Please indicate where your employees perform their work:
☐ Private Homes/Apt (%): _____ ☐ Clinics (%): _____ ☐ Nursing Homes (%): _____
☐ Other (please specify): _____

II. RISK MANAGEMENT AND SAFETY PROGRAMS

Are independent contractors required to carry their own workers' compensation insurance? ☐ Yes ☐ No

How many independent contractors are being used? _____

What are the duties of the independent contractors? _____

Are independent contractors' medical licenses checked annually? ☐ Yes ☐ No

Are copies of the insurance certificates obtained annually and kept on file? ☐ Yes ☐ No

Do employees drive personal or company vehicles to and from clients during the workday? ☐ Personal ☐ Company

What is the average radius that employees drive during the workday (miles)? _____

Are Motor Vehicle Reports (MVR) checked annually for all employees and/or Independent Contractors who drive as part of their job? ☐ Yes ☐ No

Are employees provided with training and the proper equipment for individual patient care? ☐ Yes ☐ No

Are documented proper procedures for safe lifting provided to employees? ☐ Yes ☐ No

Is a formal safety program in place? ☐ Yes ☐ No

If a formal safety program is in effect, please indicate applicable elements:

☐ Driver Safety Program ☐ 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 (if checked, describe):

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

Is there a designated person to manage workers' compensation claims? ☐ Yes ☐ No

Is there a formal Return to Work/Modified Duty Program in place? ☐ Yes ☐ No

Has a relationship been established with a preferred medical provider? ☐ Yes ☐ No

III. INSURANCE INFORMATION

Has the applicant had continuous workers' compensation (WC) coverage for the past two years? ☐ Yes ☐ No

Has the applicant's WC been cancelled for nonpayment within the last 3 years? ☐ Yes ☐ No

Has the applicant's WC been cancelled for underwriting reasons, other than a carrier appetite change? ☐ Yes ☐ No

Is the applicant's current WC provided through an Assigned Risk Plan? ☐ Yes ☐ No

Does the applicant supply any WC to other employees on a temporary or permanent basis? ☐ Yes ☐ No

Has the applicant's WC been cancelled for nonpayment within the last 3 years? ☐ Yes ☐ No

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: _____
(Please Type or Print)

Signature: _____ **Date:** _____