



Insurance Solutions for the Staffing Industry
A Division of PMC Insurance Group
A National Workers' Compensation Wholesaler



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Temporary Staffing Supplemental Application Workers' Compensation

I. CONTACT INFORMATION

APPLICANT INFORMATION

Applicant Name: _____
 Applicant Contact: _____
 Business Website: _____

BROKER INFORMATION

Broker Name: _____
 Broker Contact: _____
 Broker Email Address: _____

II. PRIOR PAYROLL AND PREMIUM INFORMATION

	Current Year	Prior Year (1)	Prior Year (2)	Prior Year (3)	Prior Year (4)
Premium (\$)					
Payroll (\$)					

III. GENERAL APPLICANT INFORMATION

			Details
What percentage of your anticipated annual growth for the upcoming year?			
Are you a new Venture? (If "Yes", attach all Sr. Executive resumes <u>and</u> your Pro Forma Balance Sheet prepared by an accountant)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you conducted business in your present territory for at least 3 years? (If "No", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you provide any assignments that are not temporary in nature (i.e. that do not have an end date)? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you required to be licensed or register as a PEO (Professional Employer Organization) in any of the states in which you operate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you provide any PEO services? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are there any other commonly owned businesses that are separately insured? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are there any states in which you operate in that are covered elsewhere? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you hire day laborers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you provide group transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you employ 100 or more workers at any single work location?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Do you have any outstanding WC premium or audit issues from the last three policy terms? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you supply workers to construction operations in California?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do any of your clients have exposures to Maritime operations subject to the USL&H Act, the Admiralty Law or the Outer Continental Shelf Lands Act? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do any of your clients have exposures to the following Acts: Migrant and Seasonal Agricultural Worker Protection Act, Federal Employers' Liability Act, Federal Coal Mine Health & Safety Act, Defense Base Act? (If "Yes" provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you requesting Employer's Liability ("Stop Gap") in any of the following states: ND, OH, WA and WY? (If "Yes", provide annual premium for each state.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have foreign travel exposures? (If "Yes", provide details concerning countries, duration, and number of employees.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

IV. EMPLOYEE SCREENING

Does your New Hire Program include the following?			Details
Formal written job application	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Criminal background checks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Reference checks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Motor vehicle checks on drivers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Job experience & placement certification requirements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pre-employment physicals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drug testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Probationary period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Minimum experience requirements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any additional information (If "Yes", please provide details)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

V. EMPLOYEE BENEFITS

Does your Employee Benefits program include the following?					
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Waiting Period for Eligibility	% of Employee Participation	Details
Health Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Long-Term Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Short-Term Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Paid Vacation Days	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Paid Sick Days	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

VI. CLIENT INFORMATION

Average number of new clients added annually?								
Client Exposure Breakdown (List the number of clients you have for each industry and the total number of employees assigned to each industry)								
	# of Clients	# of Employees			# of Clients	# of Employees		
Light Industrial				Wholesale/Retail:				
Heavy Industrial				Clerical (Professional):				
Construction (Trade):				Clerical (General):				
Construction (General):				Medical:				
Total # of Office Staff:				Total # of Temporary Placements Last Year:				
# of W2's:		# of 1099's:		Do you require Independent Contractors to carry their own WC coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "No", please explain reason:	
Profile of the Five Clients with the Highest Number of Employees You Provide:								
Customer Name	Description of work performed by your employees			Class Code	State	Payroll	Clients' # of Employees	# of Temp Employees

VII. CLIENT SCREENING

			Details
Do you have established criteria for new client selection? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you complete job hazard assessments for all new clients or new tasks? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have procedures in place to eliminate clients for poor safety practices or loss experience?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you review the client's new worker orientation procedure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you review client's response procedures for emergency or accidents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you inspect worksites for safety "prior" to employee placement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you or the client provided employees with a description of the job assignment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you or the client provide safety training? (If "Yes", provide details.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

VIII. SAFETY MANAGEMENT BY APPLICANT

Does your Safety Program include the following?			Details:
Written safety plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Full time safety director (If "Yes", provide name and title)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Safety committee	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Accident investigation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Employer provided safety equipment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Employee training for lifting, ergonomics, universal precautions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Employee safety meetings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Loss Control/Safety incentives	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Light duty/early return to work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

IX. CLAIMS MANAGEMENT & REPORTING

Does your Claims Management program include the following?			Details:
Full time claims manager	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Claim fraud investigation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Established injury reporting procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Require all WC claims be reported within 24 hours	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Drug testing after injury occurs (If "Yes", please provide details on procedures)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
A process to identify claims frequency & claims trends	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mid-term monitoring and reporting of trends in claim frequency and severity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

X. APPLICANT SIGNATURE

Notice: This application is for the purpose of obtaining a quotation and does not bind the applicant or the Company to provide the insurance. The Undersigned declares that to the best of his/her knowledge, the statements set forth herein are true. If the information supplied herein changes between the date completed and the effective date of the insurance, the undersigned shall notify the Company of the changes and the Company reserves the right to modify or withdraw any offer for insurance.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or, conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject such person to criminal and civil penalties.

Applicant Name: _____ Date: _____
Please type or print

Applicant Signature: _____