PMC INSURANCE GROUP
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Healthcare Supplemental Application
Workers' Compensation

I. BACKGROUND OPERATIONS

Applicant Name: DBA's (if any):

1. Does Common ownership (>50%) exist with any other operations? ○ Yes ○ No
2. Website:
3. Date business first began:
4. Annual revenue:
5. Total # of employees:
6. Total # of full-time employees:
7. Total # of part-time employees:
8. Total # of W2 employees:
9. Total # of 1099 employees:
10. 1099's show proof of Workers' Comp coverage? ○ Yes ○ No
11. Total # of volunteers:
12. What % of operations is temp staffing? %
13. Are 24-hour services provided (other than in shifts)? ○ Yes ○ No
14. What % of employees are live-in caregivers? %
15. What % of employees care for their own family members? %
16. Agents of clientele served?
    < 19 % 19-55 % > 55 %
17. Are motor vehicles checked at least annually? ○ Yes ○ No ○ N/A
18. Is group transportation provided? ○ Yes ○ No
19. If a facility is owned, is it OSHA compliant? ○ Yes ○ No ○ N/A

II. SERVICES PROVIDED (check all that apply)

- ☐ In-Home – Skilled Nursing
- ☐ In-Home – Non-Professional
- ☐ Hospice Provider
- ☐ Physical Rehab Facility
- ☐ Senior Skilled Nursing Facility
- ☐ ALF / Assist. Residential Homes
- ☐ Progressive Senior Living
- ☐ Senior Day Center
- ☐ Community Hospital
- ☐ Addiction Treatment Services
- ☐ Behavioral Health Services
- ☐ Developmentally Challenged

III. WHERE EMPLOYEES PERFORM WORK (check all that apply)

- Personal Residences %
- Senior Care Facility %
- Physical Rehab Center %
- Hospice Center %
- Hospitals %
- Outpatient Facility %
- Impatient Facility Center %
- Doctor / Dentist Office %
- Community Center %
- Day Center %
- Schools %
- Correctional Facilities %
- Mobile Units %
- Remote Home Offices %
- Corporate Office %
- Other:

IV. SAFFETY PROGRAMS AND TRAINING (check all that apply)

- ☐ New Employee Orientation Program
- ☐ Formal Accident/Injury investigation
- ☐ Labor/Management Safety Committee
- ☐ Proper Patient Handling/Transfer Training
- ☐ Patient Lists Provided & Utilized
- ☐ Drug Free Workplace Program
- ☐ Written Safety Manual
- ☐ Formal Written Accident Report
- ☐ Safety Incentive Program
- ☐ Post-Accident Drug Testing Team
- ☐ Lifting Procedures Employed
- ☐ Combative Patient Training
- ☐ Safe Handling & Disposal of Needles/Sharps
- ☐ Workplace Violence Training and Procedures
- ☐ Bloodborne Pathogens/Infectious Disease Training
- ☐ Return to Work/Light Duty Program in Place
- ☐ Home Site Safety Surveys Conducted & Documented
- ☐ Other:

V. HIRING AND SCREENING PRACTICES (check all that apply)

- ☐ Written Application
- ☐ Reference Checks
- ☐ Pre-hire Physical
- ☐ Pre-Hire Drug Testing
- ☐ Employee Handbook w/ Sign-Off
- ☐ Formal Job Description Provided
- ☐ Validate Work History
- ☐ Child Abuse Clearance
- ☐ Criminal background checks
- ☐ Personal Interview (virtual or in-person)
- ☐ Verification of certification and/or licenses
- ☐ Documentation or any pre-existing injuries

VI. PRIOR WORKERS' COMPENSATION INFORMATION

	Current Year	Prior Year 1	Prior Year 2	Prior Year 3	Prior Year 4
Premium:					
Payroll:					
Carrier:					

Has the applicant had continuous WC coverage for the past 2 years? ○ Yes ○ No
Has the applicant's WC insurance been canceled for nonpayment within the last 3 years? ○ Yes ○ No
Has the applicant's WC been canceled or non-renewed for Underwriting Reasons? ○ Yes ○ No
Current Professional/General Liability Insurance Carrier:
Current Professional/General Liability Effective Date:

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

Name: Signature: Date: