SUPPLEMENTAL APPLICATION FORM

STATE COMPENSATION INSURANCE FUND

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

Section 1 - Trade Name (i.e., DBA)

Current: Seaside Candy

Prior (if applicable):

Section 2 - Business Ownership

Legal Name: Angela Frank

Legal Entity (check one):

☐	1	Individual (If married, check Husband & Wife)	☐	N	Non-Profit Organization	☐	C	Conservatorship
☐	2	Husband & Wife (Both names required in Legal Name.)	☐	3	Joint Venture	☐	E	Estate
☐	4	General Partnership	☐	8	Public Agency	☐	T	Trust
☐	L	Limited Partnership	☐	P	Incorporated Public Agency	☐	6	Association
☐	5	Corporation	☐	9	Labor Union	☐	J	Joint Employer
☐	M	Non-Profit Corporation	☐	U	Incorporated Labor Union	☐	A	Common Ownership
						☐	7	Other:

Section 3 - Licenses

2101 Farm Labor Contractor License:

3405 Contractor's State License Board No./Type/Expiration Date:

3408 PUC/ICC License Number:

3409 Other License Numbers required to do business in CA (please specify):

Section 4 - Additional Business Information

2075 Phones: Bus. (619)646-9931 Home ( ) -

2075 FAX Number: ( ) -

2075 E-Mail Address: 642oceanlane@gmail.com

2099 State Employer Identification Number:

Section 5 - Social Security Number(s)

2096

Please provide the Social Security Number(s)* for individual owner, husband, wife, corporate officers, or general partners. Attach a separate page if necessary.

(1) Name: Angela Frank *Social Security Number: 462127970

(2) Name: *Social Security Number: - -

(3) Name: *Social Security Number: - -

(4) Name: *Social Security Number: - -

***DISCLOSURE STATEMENT**

Providing Social Security Numbers is voluntary. If the principals do not wish to provide Social Security Numbers, other acceptable identification shall include: 1) Federal Employer Identification Number (FEIN), 2) State Employer Identification Number (SEIN), 3) Contractor's License or 4) any applicable business license pertinent to the trade or business.

Section 6 - General Information

Do any of the following pertain to the operations of this risk? **Please explain all "yes" answers to questions 1-10 in the "Remarks" section on page 2.**

	Yes	No		Yes	No
1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press)?	☐	☑	8. Have any location/operations for which coverage is not requested?	☐	☑
2. Employ any relatives?	☐	☑	9. Have any operations outside of California?	☐	☑
3. Employ any minors (under age 18)?	☐	☑	10. Perform any asbestos removal?	☐	☑
4. Make any cash payments to employees or subcontractors?	☐	☑	11. Member of any trade or business association?	☐	☑
5. Provide meals or lodging in lieu of wages?	☐	☑	Please indicate:		
6. Pay any employees by the piece?	☐	☑			
7. Have any work at a maritime or offshore facility?	☐	☑			

Section 7 - Has the business or any principal of the business declared bankruptcy in the last seven years? ☐ **Yes** ☑ **No, skip to Section 8**

Name of Principal:

3105 Chapter of bankruptcy filed (check as applicable): ☐ 7 ☐ 11 ☐ 13 ☐ Other:

Date filed: Case Number: Status: ☐ pending ☐ dismissed ☐ discharged

Court where case was filed (Please provide us with a filed, stamped copy of the "Petition for Relief".):

Section 8 - Was this operation all or part of an existing business that was purchased or acquired? ☐ **Yes** ☑ **No, skip to Section 9**

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What percentage of the business was acquired?: Date ownership changed:

Prior business owner's name and address:

Name:

Address:

Name of Business:

Is the prior owner(s) related to the new owner(s)? ☐ No ☐ Yes, Relationship:

Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? ☐ No ☐ Yes, please explain:

Were more than 50% of the current employees hired since the acquisition? ☐ Yes ☐ No

Are those new employees earning more than 50% of the payroll? ☐ Yes ☐ No

Section 9 - Management Practices

Please indicate if you offer: Employee Assistance Program ☐ Paid Vacations ☐ Paid Sick Leave ☐

Do you have a minimum of 2 employees? ☐ No ☐ Yes

If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) ☐ No ☐ Yes

If yes, do you pay at least 50% of the Health Insurance premium? ☐ No ☐ Yes, Name of Health Insurance Carrier:

Please check off the hiring practices implemented by your company: Job Descriptions ☐ Pre-placement Medical Screening ☐ Pre-placement Drug Testing ☐ Drug-free Workplace ☐ Pre-employment Reference Check ☐ Union Employees ☐

Do you have an injury and illness Prevention Program? ☐ No ☐ Yes

Do you have a written early return-to-work program for employees injured on the job? ☐ No ☐ Yes

Do you document: Employee Training ☐ Facility Inspections ☐

Describe your housekeeping: Good ☐ Fair ☐ Poor ☐ Describe the condition of your equipment: Good ☐ Fair ☐ Poor ☐

Have you received any OSHA citations within the past year? ☐ No ☐ Yes (Please explain in "Remarks.")

Does the business provide temporary employees? ☐ No ☐ Yes (Please explain in "Remarks.")

Section 10 - Remarks (Attach a separate sheet if necessary.)

Section 11 - Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

BROKER ACCESS NUMBER	FIRM NAME		
0030	Ideal Choice Insurance Agency, Inc.		
ADDRESS	CITY	STATE	ZIP
1237 Palm Avenue	Imperial Beach, CA 91932		
PHONE NUMBER	FAX NUMBER		
(619)423-7172	(619)374-2319		

SIGNATURE

To be completed by broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Name: _____ Title: Broker

Please print Please print

Signature: _____ Date: 08/15/2016

(FAXed applications must be followed up with original document/signature.)

ACORD™ WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 08/15/2016

AGENCY	PHONE (A/C, No, Ext): 619-423-7172	COMPANY	UNDERWRITER
	FAX (A/C, No): 619-374-2319		
Ideal Choice Insurance Agency, Inc. 1237 Palm Avenue Imperial Beach, CA 91932 imperialbeachins@yahoo.com		APPLICANT NAME: Seaside Candy	INTERNET ADDRESS: 642oceanlane@gmail.com
		MAILING ADDRESS (including ZIP code): SAME	
		YRS IN BUS: 1 / SIC:	✔ INDIVIDUAL / PARTNERSHIP / CORPORATION / SUBCHAPTER "S" CORP / LLC / OTHER:
CODE: / SUB CODE:		CREDIT BUREAU NAME:	ID NUMBER:
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER: 462127970 / NCCI ID NUMBER	OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER

STATUS OF SUBMISSION

✔ QUOTE
☐ ISSUE POLICY
☐ BOUND (Give date and/or attach copy)
☐ ASSIGNED RISK (Attach ACORD 133)

BILLING/AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN		AUDIT	
☐ AGENCY BILL	☐ ANNUAL	☐ OTHER:	✔ AT EXPIRATION	☐ MONTHLY
✔ DIRECT BILL	☐ SEMI-ANNUAL		☐ SEMI-ANNUAL	☐ OTHER:
	☐ QUARTERLY	% DOWN:	☐ QUARTERLY	

LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE
	150 Palm Ave Imperial Beach CA 91932

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	☐ PARTICIPATING / ☐ NON-PARTICIPATING	RETRO PLAN
08/17/2016	08/17/2017			

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES	AMOUNT/%	OTHER COVERAGES
	$ 1,000,000 EACH ACCIDENT		☐ MEDICAL		☐ U.S.L. & H. / ☐ MANAGED CARE OPTION
	$ 1,000,000 DISEASE-POLICY LIMIT		☐ INDEMNITY		☐ VOLUNTARY COMP
	$ 1,000,000 DISEASE-EACH EMPLOYEE				☐ FOREIGN COV

DIVIDEND PLAN/SAFETY GROUP

ADDITIONAL COMPANY INFORMATION

RATING INFORMATION

STATE	LOC	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES FULL TIME	# EMPLOYEES PART TIME	ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
CA		8017(1)		Retail Store - NOC	0	1	8250		

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS

	FACTOR	FACTORED PREMIUM
TOTAL		$
INCREASED LIMITS		$
DEDUCTIBLE		$
		$
EXPERIENCE MODIFICATION		
LOSS CONSTANT	N/A	$
ASSIGNED RISK SURCHARGE		$
ARAP		$
CONSENT TO RATE		$
PREMIUM DISCOUNT		$
EXPENSE CONSTANT	N/A	$
		$
TOTAL EST ANNUAL PREMIUM	N/A	$

MINIMUM PREMIUM $ DEPOSIT PREMIUM $

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

#	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION
1	Angela Frank							

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS ☐ LOSS RUN ATTACHED

YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT. CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

Retail Candy Store and Property Managment

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?		✔	16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		✔
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)		✔	17. ANY OTHER INSURANCE WITH THIS INSURER?		✔
			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO		✔
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		✔	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		✔
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		✔	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		✔
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		✔	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		✔
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)		✔	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		✔
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		✔	23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		✔
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?		✔	24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITIY NAME(S) AND POLICY NUMBERS(S).		✔
9. ANY GROUP TRANSPORTATION PROVIDED?		✔			
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		✔			
11. ANY SEASONAL EMPLOYEES?		✔			
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		✔			
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		✔			
14. DO EMPLOYEES TRAVEL OUT OF STATE?		✔			
15. ARE ATHLETIC TEAMS SPONSORED?		✔			

CONTACT INFORMATION

IN-SPECTION	PHONE:	619-646-9931
	NAME:	
ACCTNG RECORD	PHONE:	
	NAME:	
CLAIMS INFO	PHONE:	
	NAME:	

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER

ADDITIONAL LOCATION/ RATING INFORMATION

LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP

RATING INFORMATION

					# EMPLOYEES		ESTIMATED ANNUAL		ESTIMATED ANNUAL
STATE	LOC	CLASS CODE	COMPANY USE	CATEGORIES/DUTIES/CLASSIFICATIONS	FULL TIME	PART TIME	REMUNERATION	RATE	PREMIUM