

SUPPLEMENTAL APPLICATION FORM

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

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

Current:

Prior (if applicable):

Section 2 - Business Ownership

Legal Name:

Legal Entity (check one):

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

Section 3 Liconcos

Section	n 3 - Licenses	Section 4 - Additional Business Information							
2101	Farm Labor Contractor License:	20	075						
			Phones: Bus. () - Home () -						
3405	Contractor's State License Board No./Type/Expiration Date:	20	075						
			FAX Number: () -						
3408	PUC/ICC License Number:	20	075						
			E-Mail Address:						
3409	Other License Numbers required to do business in CA (please specify):	20	999						
			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: _____

(2)Name:

(3)

Name: ______Name: _____ (4)

*Social Security Number: *Social Security Number: _____ *Social Security Number: *Social Security Number: - -

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***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			8. Have any location/operations for which coverage is								
materials (e.g., power press)?			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 busines	s declare	ed bank	ruptcy in the last seven years? 🗌 Yes 🗌 No, skip to S	Section 8							
Name of Principal:											
3105 Chapter of bankruptcy filed (check as applicable):	7		□ 11 □ 13 □ Other:								
Date filed: Case Number:	Status:	D p	ending dismissed disch	arged							
Court where case was filed (Please provide us with a filed, sta	mped cop	by of the	e "Petition for Relief".):								



SUPPLEMENTAL APPLICATION FORM

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

What percentage of the business was acquired?: Date ownership changed:
Prior business owner's name and address:
Name:Address:
Address.
Name of Business:
Is the prior owner(s) related to the new owner(s)?
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? 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?
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.)
0030
BROKER ACCESS NUMBER FIRM NAME
ADDRESS CITY STATE ZIP
PHONE NUMBER FAX NUMBER
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

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of a 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:	
	Please print		Please print
Signature:		Date:	
	(FAXed applications must be followed up with original document/signature.)		

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INDIVIDUALS INCLUDED/EXCLUDED

PÆ	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 SHIP% DUTIES INC/EXC CLASS CODE REMUNERATIO											
	1		1			1	1						

PRIOR CARRIER INFORMATION/LOSS HISTORY

	IFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTIO	LOSS RUN ATTACHED				
YEAR	CARRIER & POLICY NUMBER	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.

GENERAL INFORMATION					
EXPLAIN ALL "YES" RESPONSES	Y	ES NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRA	FT?		16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVI STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TR. 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 O	/ER 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 SUBCOM	ITRACTED)		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		
9. ANY GROUP TRANSPORTATION PROVIDED?			INCLUDING ENTITIY NAME(S) AND POLICY NUMBERS(S). CONTACT INFORMATION		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			IN- PHONE:		
11. ANY SEASONAL EMPLOYEES?			SPECTION NAME:		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			ACCTNG PHONE:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			RÉCORD NAME:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?			CLAIMS PHONE:		
15. ARE ATHLETIC TEAMS SPONSORED?			INFO NAME:		
			OMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKER TIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BE		
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REMARKS					
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ACORD 130 (2002/09)					

ACORD 130 (2002/09)

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ATTACH TO COMMERCIAL WORKERS COMPENSATION APPLICATION