

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):

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

2075

FAX Number: () -

2075

E-Mail Address:

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: _____	*Social Security Number: _____
(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)?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have any location/operations for which coverage is not requested?	<input type="checkbox"/>	<input type="checkbox"/>
2. Employ any relatives?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have any operations outside of California?	<input type="checkbox"/>	<input type="checkbox"/>
3. Employ any minors (under age 18)?	<input type="checkbox"/>	<input type="checkbox"/>	10. Perform any asbestos removal?	<input type="checkbox"/>	<input type="checkbox"/>
4. Make any cash payments to employees or subcontractors?	<input type="checkbox"/>	<input type="checkbox"/>	11. Member of any trade or business association?	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide meals or lodging in lieu of wages?	<input type="checkbox"/>	<input type="checkbox"/>	Please indicate: _____		
6. Pay any employees by the piece?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Have any work at a maritime or offshore facility?	<input type="checkbox"/>	<input type="checkbox"/>			

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)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Relationship: _____	
Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____	
Were more than 50% of the current employees hired since the acquisition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are those new employees earning more than 50% of the payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 9 - Management Practices

Please indicate if you offer: Employee Assistance Program <input type="checkbox"/>		Paid Vacations <input type="checkbox"/>		Paid Sick Leave <input type="checkbox"/>	
Do you have a minimum of 2 employees? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, do you pay at least 50% of the Health Insurance premium? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Health Insurance Carrier: _____					
Please check off the hiring practices implemented by your company: Job Descriptions <input type="checkbox"/>					
Pre-placement Drug Testing <input type="checkbox"/>		Drug-free Workplace <input type="checkbox"/>		Pre-employment Reference Check <input type="checkbox"/>	
Do you have an injury and illness Prevention Program? <input type="checkbox"/> No <input type="checkbox"/> Yes		Pre-placement Medical Screening <input type="checkbox"/>			
Do you have a written early return-to-work program for employees injured on the job? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Do you document: Employee Training <input type="checkbox"/>		Facility Inspections <input type="checkbox"/>			
Describe your housekeeping: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>		Describe the condition of your equipment: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>			
Have you received any OSHA citations within the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")					
Does the business provide temporary employees? <input type="checkbox"/> No <input type="checkbox"/> 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 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: _____ <div style="text-align: center; font-size: small;">Please print</div>	Title: _____ <div style="text-align: center; font-size: small;">Please print</div>
Signature: _____ <div style="text-align: center; font-size: x-small;">(FAXed applications must be followed up with original document/signature.)</div>	Date: _____

ACORDTM WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext):	COMPANY		UNDERWRITER	
	FAX (A/C, No):			INTERNET ADDRESS	
	MAILING ADDRESS (including ZIP code)		APPLICANT NAME		
			YRS IN BUS SIC INDIVIDUAL CORPORATION LLC PARTNERSHIP SUBCHAPTER "S" CORP OTHER:		
CODE:	SUB CODE:	CREDIT BUREAU NAME:		ID NUMBER:	
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER	NCCI ID NUMBER	OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	

STATUS OF SUBMISSION

BILLING/AUDIT INFORMATION

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
<input type="checkbox"/> BOUND (Give date and/or attach copy)		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL <input type="checkbox"/> OTHER:	<input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> OTHER:
			<input type="checkbox"/> QUARTERLY % DOWN:	<input type="checkbox"/> QUARTERLY

LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE		PROPOSED EXP DATE		NORMAL ANNIVERSARY RATING DATE		PARTICIPATING NON-PARTICIPATING		RETRO PLAN	
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY			PART 3 - OTHER STATES INS	DEDUCTIBLES		AMOUNT/%	OTHER COVERAGES	
	\$ EACH ACCIDENT				<input type="checkbox"/> MEDICAL <input type="checkbox"/> INDEMNITY	<input type="checkbox"/> U.S.L. & H. VOLUNTARY COMP <input type="checkbox"/> FOREIGN COV		<input type="checkbox"/> MANAGED CARE OPTION	
	\$ DISEASE-POLICY LIMIT								
	\$ DISEASE-EACH EMPLOYEE								
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION							

RATING INFORMATION

STATE	LOC	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS		FACTOR	FACTORED PREMIUM			
	TOTAL		\$			
	INCREASED LIMITS		\$			
	DEDUCTIBLE		\$			
			\$			
	EXPERIENCE MODIFICATION					
	LOSS CONSTANT	N/A	\$			
	ASSIGNED RISK SURCHARGE		\$			
	ARAP		\$			
	PREMIUM DISCOUNT		\$			
	EXPENSE CONSTANT	N/A	\$			
MINIMUM PREMIUM	\$	DEPOSIT PREMIUM	\$	TOTAL EST ANNUAL PREMIUM	N/A	\$

ACORD 130 (2002/09)

PLEASE COMPLETE REVERSE SIDE

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[illegible][illegible]

<p>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.</p>
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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?			
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?				18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO			
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?				19. ARE EMPLOYEE HEALTH PLANS PROVIDED?			
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?				20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?			
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)				21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?			
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?				22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?			
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?				23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?			
9. ANY GROUP TRANSPORTATION PROVIDED?				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).			
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?				CONTACT INFORMATION			
11. ANY SEASONAL EMPLOYEES?							
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				IN- SPECTION	PHONE:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?					NAME:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?				ACCTNG RECORD	PHONE:		
15. ARE ATHLETIC TEAMS SPONSORED?					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

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