

## 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			Conserva	atorship	
☐ 2 Husband & Wife (Both names required in Legal Name.)			3	Joint Venture		-	Estate		
4 General Partnership			8	Public Agency		T	Trust		
L Limited Partnership			P	Incorporated Public Agency			Associati		
5 Corporation		$\Box$	9	Labor Union	1 -		Joint Em		
M Non-Profit Corporation		ш	U	Incorporated Labor Union	1 -		Common	Owners	ship
						7	Other:		
Section 3 - Licenses			6	Section 4 - Additional Busine	ogg I	nform	ation		
					ess 1	шогш	ation		
2101 Farm Labor Contractor License:			] [	Phones: Bus. ( ) -		Home	( )	-	
3405 Contractor's State License Board No./Type/Expiration Date:			J□	FAX Number: ( )	-				
3408 PUC/ICC License Number:  2075  E-Mail Address:									
3409 Other License Numbers required to do business in CA (please specify):  State Employer Identification Number:									
Section 5 - Social Security Number(s)									
Please provide the Social Security Number(s)* for individed Attach a separate page if necessary.  (1) Name: (2) Name:			*	Social Security Number:	_		partners.		
· · · · · · · · · · · · · · · · · · ·						_			
*Social Security Number: *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 ex	xplain a	ll "ye	s" ans	wers to questions 1-10 in the "Rem	arks	" section	on page 2.		
1. Use any equipment that bends, forms, shapes, or cuts	Yes	N	.	8. Have any location/operations for v	which	coverage	e is	Yes	No
materials (e.g., power press)?  2. Employ any relatives?	H	╁╞		not requested?  9. Have any operations outside of Ca	lifor	nin?		$\vdash$	+ #-
3. Employ any minors (under age 18)?	<del>                                     </del>	╁┾		Perform any asbestos removal?	11101	11a :		<del>                                     </del>	<del>                                     </del>
Employ any minors (under age 18)?      Make any cash payments to employees or subcontractors?	片片	╁┾		1. Member of any trade or business a	10000	iation?		<del>     </del>	+ #-
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5. Provide meals or lodging in lieu of wages?	片片	╁┾	┽┤	Please indicate:					
6. Pay any employees by the piece? 7. Have any work at a maritime or offshore facility?	H	╁╞	+	-					
any more as a marriante of offshore facility.									
Section 7 Has the hydrogen on any natural of the best of	deala	od L	onl	in the last source	<b>T T</b> 7	oc 🗆	No. 11 :	G	)
Section 7 - Has the business or any principal of the business	ueciar	ea D	ankru	ipicy in the last seven years?	Y	es	No, skip to	Section 8	5
Name of Principal:									
Chapter of bankruptcy filed (check as applicable):	] 7			] 11	Ot	her:			
	tatus:	Г	nen	iding dismisse			disc	harged	
Court where case was filed (Please provide us with a filed, stam		pv o						0-4	
court made case was free (Freuse provide as with a free, start	-p-u -0	P) 0							

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Yes

No, skip to Section 9

Section 8 - Was this operation all or part of an existing business that was purchased or acquired?



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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:
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)?
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
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
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.")
Does the business provide temporary employees: 10 10 1 1es (Flease 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: Title:
Please print Please print
Signature: Date:
(FAXed applications must be followed up with original document/signature.)

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ACORD, WORKERS COMPENSATION APPLICATION												DATE	(MM/DD/YYYY)						
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ACORD 130 (2002/09)

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DATE

PRODUCER'S SIGNATURE

NATIONAL PRODUCER NUMBER

APPLICANT'S SIGNATURE

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