# 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: SA Smog

Prior (if applicable):

**Section 2 - Business Ownership**

Legal Name: Susana Arce

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) 339-1900 Home ( ) -

**2075** FAX Number: ( ) -

**2075** E-Mail Address: none@no-ip.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: Susana Arce *Social Security Number: 208182816

(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**

# 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:

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.)**

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

Please print Please print

Signature: _____ Date: 02/01/2018

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

# ACORD™ WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 02/01/2018

| AGENCY | COMPANY | UNDERWRITER |
|---|---|---|
| PHONE (A/C, No, Ext): 619-423-7172<br>FAX (A/C, No): 619-374-2319<br>Ideal Choice Insurance Agency, Inc.<br>1237 Palm Avenue<br>Imperial Beach, CA 91932<br>imperialbeachins@yahoo.com | | |

| APPLICANT NAME | INTERNET ADDRESS |
|---|---|
| SA Smog | none@no-ip.com |

MAILING ADDRESS (including ZIP code): SAME

| YRS IN BUS | SIC | | | | | | |
|---|---|---|---|---|---|---|---|
| 3 | | ☐ INDIVIDUAL | ☐ CORPORATION | ☐ LLC |
| | | ☐ PARTNERSHIP | ☐ SUBCHAPTER "S" CORP | ☐ OTHER: |

| CODE: | SUB CODE: | CREDIT BUREAU NAME: | ID NUMBER: |
|---|---|---|---|
| AGENCY CUSTOMER ID | | FEDERAL EMPLOYER ID NUMBER: 208182816 | 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 |
|---|---|
| | 609 Arizona St Chula Vista CA 91911 |
| | |
| | |

## POLICY INFORMATION

| PROPOSED EFF DATE | PROPOSED EXP DATE | NORMAL ANNIVERSARY RATING DATE | | RETRO PLAN |
|---|---|---|---|---|
| 02/05/2018 | 02/05/2019 | | ☐ PARTICIPATING<br>☐ NON-PARTICIPATING | |

| 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 | | 4511 | | Analytical or Testing Laboratories | 2 | | 30000 | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

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 $


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## 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 | Susana Arce | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## 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.

Smog testing for automobiles.

## GENERAL INFORMATION

| EXPLAIN ALL "YES" RESPONSES | YES | NO |
|---|---|---|
| 1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT? | | ✔ |
| 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) | | ✔ |
| 3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET? | | ✔ |
| 4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER? | | ✔ |
| 5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS? | | ✔ |
| 6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED) | | ✔ |
| 7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.? | | ✔ |
| 8. IS A WRITTEN SAFETY PROGRAM IN OPERATION? | | ✔ |
| 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? | | ✔ |

| EXPLAIN ALL "YES" RESPONSES | YES | NO |
|---|---|---|
| 16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE? | | ✔ |
| 17. ANY OTHER INSURANCE WITH THIS INSURER? | | ✔ |
| 18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO | | ✔ |
| 19. ARE EMPLOYEE HEALTH PLANS PROVIDED? | | ✔ |
| 20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY? | | ✔ |
| 21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? | | ✔ |
| 22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? | | ✔ |
| 23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS? | | ✔ |
| 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). | | ✔ |

**CONTACT INFORMATION**

| | | |
|---|---|---|
| IN-SPECTION | PHONE: | (619) 339-1900 |
| | NAME: | Susana Arce |
| 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 |
|---|---|
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## RATING INFORMATION

| | | | | | # EMPLOYEES | | ESTIMATED ANNUAL | | ESTIMATED ANNUAL |
|---|---|---|---|---|---|---|---|---|---|
| STATE | LOC | CLASS CODE | COMPANY USE | CATEGORIES/DUTIES/CLASSIFICATIONS | FULL TIME | PART TIME | REMUNERATION | RATE | PREMIUM |
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ATTACH TO COMMERCIAL WORKERS COMPENSATION APPLICATION