TREAN CORPORATION

Healthcare Supplemental

Named Insured: _____

Website: _____

Detailed Description of Operations: _____

Hours of Operation: _____

Driving or Delivery Mileage % of Each:	☐ <50	☐ 50-100	☐ 100+	☐ N/A
Reason for Driving:	☐ Client Off Site Activities	☐ Client Appointments	**Other, list:**	
Group Transportation:	☐ No	☐ Yes	**If yes, # of Employees:**	☐ #
Are Vehicles Company Owned:	☐ No	☐ Yes	☐ N/A	
Vehicle Maintenance Program:	☐ In-House	☐ Outside Vendor	☐ No	☐ N/A
Distracted Driving policy in place:	☐ No	☐ Yes	☐ N/A	
Drivers Training:	☐ No	☐ Yes	☐ N/A	
Overnight Travel by Employees:	☐ No	☐ Yes	**If yes, frequency:**	
Employees (# of Each):	☐ Full Time	☐ Part Time	☐ Seasonal	☐ Volunteers
How are Employees Paid:	☐ Hourly	☐ Commission	☐ Salary	**Other:**
Benefits Offered (check all that apply):	☐ Paid Sick Time	☐ Paid Vacation	☐ 401k	☐ Retirement
Group Health Coverage:	☐ Yes	☐ No	☐ % EE Participation	☐ % Employer Paid
Pre Hire (check all that apply):	☐ Written Application	☐ Reference Checks	☐ Physicals	
	☐ Pre-Hire Drug Testing	☐ Random Drug Testing	☐ Post Accident Drug Testing	
	☐ Pre-Hire MVR Checks	☐ Annual MVR Checks	☐ Criminal Background Checks	
	Other, please list:			
Return-To-Work/Light Duty Available:	☐ Formal/Written	☐ Informal/Verbal	☐ None	
Subcontractors Used:	☐ Yes	☐ No	**If yes, what % of payroll:**	☐ %
Are COIs Obtained for Subs:	☐ Yes	☐ No	☐ N/A	
Average Annual Turnover:	☐ %			
Safety Program in Place:	☐ Formal/Written	☐ Informal/Verbal	☐ None	
Safety Training:	☐ Yes, Documented	☐ Yes, Verbal	☐ None	
Safety Meetings:	☐ Weekly	☐ Monthly	☐ Quarterly	☐ Annually
Combative Patient Training/Handling:	☐ Yes	☐ No		
Lifting Exposures:	☐ <25lbs	☐ 25-40lbs	☐ 40+lbs	☐ N/A
Lifting/Movement of Clients:	☐ No Training	☐ Training Provided	☐ N/A	
Mechanical Lift Equipment Used:	☐ Manual Lifts	☐ Lift Slings	☐ Sit to Stand Lifts	☐ Heavy Duty Lifts
	☐ Bath Lifts	☐ Hydraulic Lifts	☐ Gait Belts	☐ Pool Lifts
	☐ Wheel Chair Lifts	☐ Electric/Battery Power Lifts	**Other, list:**	
Breakdown of Client Types:	☐ % Ambulatory	☐ % Non-Ambulatory	☐ % Memory Care	☐ % Rehabilitation
	☐ % Hospice	☐ % Short Term	☐ % Long Term	☐ % Bariatric
Machinery Guarded & Maintained:	☐ Yes	☐ No	☐ N/A	
List all Personal Protective Equipment:	☐ Gloves	☐ Back Belts	☐ Protective Clothing	☐ Ear Plugs
	☐ Goggles	☐ Non-Slip Shoes	☐ Steel Toed Boots	☐ Masks
	Other, please list:			
Business Operations (check all that apply):	☐ Ambulance Services	☐ PT/OT	☐ Nursing Home	
	☐ Healthcare Staffing	☐ Home Care Services	☐ Medical Equipment Provider	
	☐ School for Challenged	☐ Group Home	☐ Social Service Organization	
	☐ Assisted Living Center	☐ Rehab Clinic	☐ Substance Abuse Counseling	
	☐ Mental Health	☐ Retirement Home	☐ Hospital	
Number of Beds in Facility:	☐ #			

Client/Resident Pay Type %'s:	☐	% Medicaid Funded	☐	% Private Pay				
# of Employees Professional Designation:	☐	RN/LPN	☐	MD/DO/PA	☐	PT/OT	☐	CP/CNA/MA
	☐	Unskilled	**Other, please list:**					
24 Continuous Hours Spent in Client's Home?	☐	Yes	☐	No	**If yes, how many EE's:**		☐	#
Do You Utilize Any 1099 Employees?	☐	Yes	☐	No	**If yes, what % of workforce:**		☐	%
Employees Over 60 Years Old:	☐	No	☐	# in Administrative	☐	# Care Providers	☐	# Other
COVID Specific procedures for EE's over 60 years old: If yes, provide details:								
COVID19 Specific Procedures:	☐	Infection Control Plan	☐	State & National Guidelines Followed				
	☐	Hand Sanitizer Provided	☐	Virtual Appointment Capability				
	☐	Residents Screened	☐	CDC & CMC Guidance Followed				
	☐	Employees Screened	☐	Isolation Rooms Available				
	Other, please list:							
Residents or Staff test positive for COVID19?	☐	# Residents	☐	# Staff	☐	None		
Positive Test Tracking:	☐	Date of 1st positive test	☐	Date of most recent positive test				
How are residents/patients suspected of COVID19 being assessed:	☐	Isolation	☐	Designated 14 Day Quarantine	☐	Daily Temperature Checks	☐	Daily Health Screens
	☐	Symptomology monitored	**Other, please list:**					
How are Staff suspected of COVID19 being handled:	☐	EE May Return to Work only if CDC/State Return to Work Criteria is met			☐	Quarantine from workplace per CDC/State guidelines		
	☐	Health Screen & Temperature Check Upon Return			**Other, list:**			
Department of Health notified on all cases:	☐	Yes	☐	No				
Travel restrictions for employees imposed:	☐	No	☐	Quarantine Required	**Other, list:**			
Contingency plan for staff shortages:	☐	Other Facility Staff Used	☐	Staffing Agency Used	**Other, list:**			
Do you have a dedicated staff member for COVID safety training and PPE use:	☐	Yes	☐	No				
Do any of your facilities accept COVID Positive Patients?	☐	No	**If Yes, Provide Details:**					
Changes made to Visitation Rules: If yes, provide details:								
Facility cleaning increased/changed:	☐	Yes	☐	No				
Communal Facility Amenities Suspended or Restricted:	☐	Yes	☐	No				
Will the Insured's staff be receiving the COVID Vaccine:	☐	No	☐	Yes	☐	**Estimated/Recieved Date**	☐	**% of Staff Vaccinated**
Required Additional Documents:	☐	Copy of COVID19 Specific Safety Plan & Procedures in Place						

Affirmation

The undersigned acknowledges and understands the information provided herein will be used to evaluate the applicant and a decision as to whether the applied to insurance company will offer workers' compensation insurance will be made, in part, based on the information provided. Signature below indicates the information provided is true and correct. This Supplemental Application must be signed by a principle, owner or partner of the entity applying for insurance.

Owner/Officer Signature: _____ **Date:** _____