Staffing Risk Supplemental

Named Insured: ____________________

Website: ____________________

Detailed Description of Operations: ____________________

State(s) of Operation: ____________________

Question				
Signed contract required from the Client Companies you lease workers to:	☐ Yes	☐ No		
Do you provide any group transportation for you temporary workers:	☐ Yes	☐ No		
Any clients provide group transportation for leased workers:	☐ Yes	☐ No		
Employee concentration of 100 or greater in any single location?	☐ Yes	☐ No		
Labor supplied for any clients with the following exposure:	☐ USL&H	☐ Admiralty Act	☐ Outer Continental Shelf Lands Act	
	☐ Railways	☐ Maritime	☐ Migrant & Seasonal Agri. Worker Protection	
	☐ Foreign Travel	☐ Defense Base Act	☐ Federal Coal Mine Health & Safety Act	
	☐ Monopolistic States	☐ Federal Employers' Liability Act		
Labor provided for any client that is not temporary (no end date to assignment):	☐ No	☐ Yes		
Do you provide any services to clients other than that of temporary labor:	☐ No	☐ Yes	**If yes, please list:**	
Do you provide any PEO services to any clients:	☐ No	☐ Yes	**If yes, please list:**	
Are you required to be licensed or registered as a PEO in any state in which you do business:	☐ No	☐ Yes	**If yes, provide details:**	
Are there any commonly owned business that are insured separately:	☐ No	☐ Yes	**If yes, provide details:**	
Is a written job description required & obtained prior to all placements:	☐ No	☐ Yes		
Do you evaluate new clients against formal & written criteria:	☐ No	☐ Yes	**If yes, provide details:**	
Are PPE requirements and a hazard assessment evaluated prior to all placements:	☐ No	☐ Yes		
Do any clients require your employees to work at heights >6' or at depths >3'?	☐ No	☐ Yes		
Do any of your clients require an Alternative Employer endorsement:	☐ No	☐ Yes		
Do you supply any of your clients with Waivers of Subrogation:	☐ No	☐ Yes		
Do you employ any workers that are older than 60 or under the age of 16:	☐ No	☐ Yes	***If yes, provide employee list & specific job duties performed**	
Clients evaluated for conditions that expose employees to dust, fumes, gases or liquids contributing to occupational disease:	☐ No	☐ Yes	**If yes, provide details:**	
Do you inspect client locations prior to employee placement:	☐ No	☐ Yes		
Do you evaluate client's injury response & claim reporting process prior to placement:	☐ No	☐ Yes		
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:			
Workers provided with a written job description prior to placement:	☐ No	☐ Yes		
Do you or your clients provide safety training:	☐ No	☐ Yes		
Do you or your clients provide job specific training:	☐ No	☐ Yes		
Driving Positions: Select Applicable items:	☐ MVR Checked	☐ Driver Training	☐ Distracted Driving Policy	
	☐ Overnight Travel	☐ 100+ Mile Radius	☐ Vehicle Maintenance Program	
Safety Program in Place:	☐ Formal/Written	☐ Informal/Verbal	☐ None	
Safety Training:	☐ Yes, Documented	☐ Yes, Verbal	☐ None	
Safety Meetings:	☐ Yes	☐ No		
If yes, frequency:	☐ Weekly	☐ Monthly	☐ Quarterly	☐ Annually

Question				
Do you have a full time safety director or manager:	☐ Yes	☐ No		
Do you have an accident investigation committee & formal investigation process:	☐ Yes	☐ No		
Do you provide employee training for lifting, ergonomics and universal precautions:	☐ Yes	☐ No		
Do you have a Light Duty / Early Return to Work Program:	☐ Yes	☐ No		
Group Health Coverage:	☐ Yes	☐ No	**If yes,% paid by employer:**	☐ %
Do you have a full time claims manager:	☐ Yes	☐ No		
Do you require all WC injuries to be reported to you within 24 hours:	☐ Yes	☐ No		
Do you monitor claims frequencies, claim trends and injury types:	☐ Yes	☐ No		
Do you monitor claims frequencies by client:	☐ Yes	☐ No		
Have you ever terminated a client due to adverse loss frequency or severity:	☐ Yes	☐ No		
Check all Industries for which you supply labor:	☐ Home Health Care	☐ Transportation Risks	☐ Distribution/Picker/Packer	☐ Trucking
	☐ Resident Health Care	☐ Parcel Delivery	☐ Retail	☐ Busing
	☐ Hospitals	☐ Farming (includes Crop Harvesting)	☐ Direct Sales or Sales Support	☐ Manufacturing
	☐ Doctor/Dentist Office Support	☐ Moving & Storage	☐ Telemarketing	☐ Construction
	☐ General Clerical Support	☐ General Warehousing	☐ Auto, Truck or Equipment Mechanics	☐ Landscaping
	Other, please list:			

Please provide a complete list of all clients, to include: Name of Client, Physical Address of Client, Class Codes by location, Number of Employees, by class code, by location, Payroll by class code & Brief description of operations & duties

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:** ______________