ARROWHEAD
Workers' Compensation

Contractor's Supplemental Application

To be completed with ACORD 130 Application

Named Insured:	Web Address:
Insured's FEIN:	

	CONTACT NAME	PHONE NUMBER
Inspections:		
Premium Audit:		
Claims:		

PRIOR PAYROLL AND PREMIUM INFORMATION

	Total Annual Payroll	Premium $
Current Year:		
Prior Year:		
Prior Year:		
Prior Year:		
Prior Year:		

OPERATIONS AND BENEFITS

Broker controlled account? ☐Yes ☐No	
Does applicant currently use a PEO or payroll service? ☐Yes ☐No	If yes, provide name of organization used:
Please provide a detailed description of the operation:	
Years in business?	Hours of operation:
No. of shifts:	Does the applicant allow employees to work more than three consecutive 12-hour shifts? ☐Yes ☐No
Is there a driving or delivery exposure? ☐Yes ☐No	Radius of operations/travel: ☐<10 miles ☐11-50 ☐50-100 ☐100+
If yes, what is the frequency? ☐Daily ☐Weekly ☐Other:	Any group transportation of employees? ☐Yes ☐No
Is a PUC/DMV filing required? ☐PUC ☐DMV ☐N/A	If yes, how provided? ☐Car ☐Truck ☐Van ☐Bus
Are vehicles company owned? ☐Yes ☐No	No. of employees transported per vehicle:
If yes, types of vehicles:	No. of vehicles used to transport:
If yes, are vehicles taken home: ☐Yes ☐No	Frequency: ☐Daily ☐Weekly ☐Monthly
No. of vehicles: / No. of drivers:	Is insured enrolled in DMV Pull program? ☐Yes ☐No
Vehicle/fleet maintenance program? ☐Yes ☐No	Are driver acceptability standards in place? ☐Yes ☐No
If yes, who does the servicing?	If yes, provide details below:
Outside vendor: ☐	
In-house mechanics: ☐	
Other: ☐	
Does insured have and enforce the following policies for drivers: Alcohol/drug use: ☐Yes ☐No Seat belt use: ☐Yes ☐No Distracted driving: ☐Yes ☐No	
Any work-related injuries as a result of a prior motor vehicle accident within the past four years? ☐Yes ☐No	
If yes, please provide details, including fault of accident and if subrogation was pursued:	
Do employees use personal vehicles for company business? ☐Yes ☐No	
Do any employees work from home? ☐Yes ☐No / No. of employees who live/work out of state: / Live: / Work:	
Any out-of-state, international or overnight (within state) travel? ☐Yes ☐No	If yes, provide details:
Why/purpose?	

Who will travel?	Where?		Duration?	Frequency?
No. of employees: (verify number is consistent w/ number on ACORD application)	Full:	Part:	Seasonal:	Volunteers:
No. of employees per location:	1.	2.	3. / 4.	Use a separate page if needed.
Avg. Annual Employee Turnover: _____%	No. of W-2s issued:		Last Year:	Previous Year:

How are employees paid? Hourly: ☐ Piece rate: ☐ Commission: ☐ Flat Salary: ☐ Other: ☐
Any interchange of labor? ☐Yes ☐No If yes, please explain: ☐Another business ☐Subsidiary ☐Between departments ☐Other

Any day laborers or temporary/employee leasing? ☐Yes ☐No		
% of union employees: _____%	Average hourly wage for employees in governing class: $	
%of non-union: _____%	Retirement/pension plan? ☐Yes ☐No	Does employer contribute? ☐Yes ☐No
Group medical provided? ☐Yes ☐No	If group medical is provided, who is the healthcare provider?	
% of employees enrolled: _____%	% paid by employer: _____%	
Do you have a wellness program (ie encourages and promotes employee health programs) in place? ☐Yes ☐No		
Do you use a specific medical provider to treat injured employees?☐Yes ☐No		
Are you currently participating in a MPN (Medical Provider Network)? ☐Yes ☐No		
If yes, please provide the name of current MPN:		
CPR training provided? ☐Yes ☐No	RTW program? ☐Yes ☐No	
No. of employees certified?	Does it include salary continuation? ☐Yes ☐No	
Has the ownership of the applicable entity changed within the past five years? ☐Yes ☐No		
If yes, please provide details:		
HIRING PRACTICES - EMPLOYEE SELECTION - CLAIMS		
Written application? ☐Yes ☐No	Pre-hire drug testing? ☐Yes ☐No	
Reference checks? ☐Yes ☐No	Background Checks? ☐Yes ☐No	Post-accident drug testing? ☐Yes ☐No
Pre/post employment physicals? ☐Yes ☐No	MVR checks? ☐Yes ☐No	
Orthopedic back testing? ☐Yes ☐No	Audio hearing tests? ☐Yes ☐No	
Formal job descriptions on file? ☐Yes ☐No	Do you have a formal written accident report? ☐Yes ☐No	
Average claim reporting time frame:	Are there set procedures for reporting claims? ☐Yes ☐No	
Is job specific training provided? ☐Yes ☐No	Are supervisors held accountable for accidents/injuries? ☐Yes ☐No	
Employee Orientation Program? ☐Yes ☐No	If yes, is the orientation:☐ Verbal only? ☐ Verbal and Documented?	
Employee to Supervisor ratio:☐ Better than 4-1 ☐ 5-1 ☐ 6-1 ☐ 7-1 ☐ >7-1		
Subcontractors used? ☐Yes ☐No	If yes, for what purpose?	
If yes, are certificates of insurance obtained and kept on file? ☐Yes ☐No		
Independent contractors used? ☐Yes ☐No	If yes, for what purpose?	
If yes, how are they paid?☐ 1099s? ☐ Other? Please explain.		
SAFETY PROGRAM AND ORGANIZATION - WORK PREMISES AND ENVIRONMENT		
Are owners active in daily operations? ☐Yes ☐No	If yes, are they excluded from coverage? ☐Yes ☐No	
Active injury & illness prevention program? ☐Yes ☐No	Has loss control services been performed in the last year?☐Yes ☐No	
Active safety incentive program? ☐Yes ☐No	Has Cal/OSHA visited/cited your business in the last year?☐Yes ☐No	
If yes, does it encompass all employees? ☐Yes ☐No	If yes, please provide explanation on separate page.	
What type of incentive?	Are safety meetings conducted? ☐Yes ☐No	
Do employees receive safety training/orientation? ☐Yes ☐No	If yes, how often?☐Daily ☐Weekly ☐Monthly ☐Quarterly ☐Other	
If yes, is the training: ☐ Formal / Documented ☐ Informal		
Do you have a safety director or risk manager? ☐Yes ☐No	Name and title:	
If yes, is the position full time or an additional responsibility of another employee?		
MSDS (Material Safety Data Sheets) available for all chemicals and products used? ☐Yes ☐No ☐N/A		
Any material handling exposures? ☐Yes ☐No	If yes, please explain:	
Any lifting exposures? ☐Yes ☐No	Forklift training provided? ☐Yes ☐No ☐N/A	
If yes,☐ <25 lbs.☐ 25-40 ☐ 40+	If yes, annual certification? ☐Yes ☐No	
If 40+, manual lifting or with assistance? Explain:		
Is all machinery/equipment properly guarded? ☐Yes ☐No ☐N/A	Any use of Baler equipment? ☐Yes ☐No	
Written lockout/tagout/blockout procedures in place? ☐Yes ☐No ☐N/A	Condition of equipment?☐ New ☐ Good ☐ Average	
Respiratory program in place? ☐Yes ☐No	Age of equipment? ☐ 0-5 years ☐ 5-10 ☐ 10-20 ☐ 20+	
What is the max. height in feet you'll work?	Please see Contractors Section for further elaboration.	
What is used? ☐ Ladder ☐ Scaffolding ☐ Scissor lifts ☐ N/A	If scaffolding used, does the insured build their own? ☐Yes ☐No	
If insured builds own scaffolding, provide % of annual operations involving scaffold setup and teardown compared to total operations: _____%		
Written Fall Protection Program? ☐Yes ☐No	Please see Contractors Section for further elaboration.	
Are all equipment operators trained/ certified?☐Yes ☐No ☐N/A	Personal protection equipment provided? ☐Yes ☐No ☐N/A	
Is the building/premises: ☐ Owned ☐ Leased?	If yes, strict enforcement of utilization? ☐Yes ☐No	
Condition of premises? ☐ Excellent ☐ Very good ☐ Average	What types of PPE?	
No. of years at current location?	Number of years of building occupied?	

This section must be completed by all applicants who are individuals, sole proprietorships, husband and wife, or partnerships (where the general partners are husband and wife).

Please list below any relatives residing in your household who are employees of your business and to whom your books and records show payments to such relatives:

Employed Relatives*

Name	Relationship to You	Job Title or Duties	Estimated Annual Remuneration

Check here if there are no relatives residing in your household that are employed in your business. ☐

***Relatives are defined as: spouse, child by birth or adoption, stepchild, grandchild, son-in-law, daughter-in-law, parent, step-parent, parent-in-law, grandparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, sister-in-law, uncle, aunt, nephew, or niece.**

Note: Per California Labor Code, as an employer you are required to include in your Workers' Compensation coverage all relatives residing in your household who are your employees. Any policy issued based on information provided in this application will exclude coverage for residing relatives if none are listed above.

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Arrowhead General Insurance Agency, Inc. must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Signature of Applicant:	Date:

CONTRACTORS

Contractors license number?	Years experience in trade?
Estimated annual gross sales?	Estimated number of jobs per year?
Percentage of work sub-contracted out? _____%	What type?

If subs used, does insured: ☐Check annually? ☐ Directly supervise subs?

Average no. of certificated collected annually?	Average no. of Waivers of Subrogation needed?

Indicate percentage of work conducted in each of the following operations (must equal 100% for each):

1.)	New Construction:	Remodeling:	Service/Repair:
2.)	Commercial:	Apts/Condos/Tract Homes:	Single Custom Homes:
3.)	Interior:	Exterior _____	

If exterior work done, what is the max height your employees will work above ground level?

Percentage of work/exposure:	<12':	12' to 24':	24' to 40':	>40':

What is used? ☐Ladder ☐Scaffolding ☐Scissor lifts ☐N/A

If insured builds own scaffolding, provide % of annual operations involving scaffold setup and teardown compared to total operations._____%

Any use of swing scaffolding? ☐Yes ☐No If yes, what percentage of total scaffolding use is swing? _____%

Any rooftop exposure? ☐Yes ☐No If yes, what percentage of total work is on commercial flat roof? _____%
What percentage is on pitched rooftop? _____%

Any work performed on skylights? ☐Yes ☐No If yes, provide details:

Any solar work? ☐Yes ☐No If yes, provide details:

Fall Protection Program in place? ☐Yes ☐No If yes, please select type below:

☐ Guardrails ☐ Safety Belt of Full Body Harness ☐ Safety Net ☐ Ladder Tie Offs ☐ Training in Ladder/Scaffold Placement

☐ Other, please describe:

Any use of cranes, booms or similar heavy construction equipment? ☐Yes ☐No

Any work below grade? ☐Yes ☐No	Max. depth in feet:	% of total work: _____%

Any confined spaces exposures? ☐Yes ☐No
If yes, please provide details on separate page – include copy of written procedures and details of Confined Spaces Training.

Any work involving asbestos, hazardous product abatement, chemical/petroleum products, USL&H, underground tank or pipe replacement? ☐Yes ☐No If yes, please explain:

Does any welding exposure exist? ☐Yes ☐No

If yes, you must complete the Welding Exposure Supplemental App and include it with your submission.

Does this risk conduct work for the government or city municipality?

Is the applicant involved in "Wrap Up" or "OCIP" projects? ☐Yes ☐No
If yes, please use the lines below to provide percentage of total payroll dedicated to these projects and advise detailed procedures on how applicant determines employee split between these projects and other contracts/projects (not Involving "wrap up" or "OCIP").

Indicate percentage of work conducted in each of the following operations or mark not applicable - ☐N/A							
Blasting _____%	Drilling _____%	Light Pole Work _____%		Demolition____%	Tunneling____%	Grading____%	Wrecking____%
Multi-story Buildings____%		Gas Mains____%	Crane Work____%	Asbestos____%	Highway Work____%		Scaffold setup____%
Roofing____%	Excavation____%	Concrete Tilt-up____%		Sewer____%	Ext. Framing____%	Structural Steel____%	
Bridge Work____%	Supervisory Only____%	Street/road Work____%		Spray Painting____%	Dock/sea walls____%	Solar____%	

Thank you.