

Workers Compensation Supplemental Information

*Aaron J. Farmer
Insurance Agency*

SECTION 1

Trade Name (i.e., DBA) _____

Business Ownership: _____

FEIN#: _____ State ID # (EDD): _____

Partners, Officers, Relatives to be Included or Excluded. (Remuneration to be included must be part of rating info section.)

Name	Date of Birth	Title/Relationship	Ownership %	Duties	Inc/Excl	Class Code	Remuneration

Workers Compensation Class Codes and Payroll:

State	Location	Class Code	Est. Annual Payroll	Duties/Classifications	Current Rate	Proposed Rate

SECTION 2

Staffing Information:

Hours of operation: _____ 24 hour exposure?: _____

Number of Employees: _____ Full Time: _____ P/T: _____ Permanent: _____ Seasonal: _____

of W2's Last Year : _____

Health Insurance Provided? _____ Employer Pay at least 50% of health premium for eligible employees?: _____

Health Care Provider: _____ Health Insurance Anniversary Date: _____

Union: _____ Non Union: _____ Retirement/401K plan: _____ What Company?: _____

Do Any of the following pertain to the operations of this risk? Please explain all "yes" answers in the "remarks" section.

Was this operation all or part of an existing business that was purchased or acquired?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Employee any relatives?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Make any cash payments to employees or subcontractors	<input type="checkbox"/> yes	<input type="checkbox"/> no
Provide meals in lieu of wages?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Have any operations outside of California?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Have a minimum of at least 2 employees?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Health benefits provided?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Pay employees by the piece?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Receive any OSHA citations within the past year?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Use any equipment that bends, forms, shapes, or cuts materials (i.e. power press?)	<input type="checkbox"/> yes	<input type="checkbox"/> no

Employment applications?	<input type="checkbox"/> yes	<input type="checkbox"/> no
References Checked?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Employee safety meetings?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Documented?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Pre employment physicals?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Drug free work environment?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Exit interviews?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Random drug testing?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Written safety program?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Disciplinary procedure?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Drug Screening?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Random drug testing?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Safety incentive plan?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Have a written early return-to-work program for employees injured on the job?	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/> yes	<input type="checkbox"/> no

Remarks: _____

Section 3

Current Carrier Information: **MUST HAVE 3 YEARS LOSS HISTORY! If you need help don't hesitate to ask!**

Year	Carrier	Policy Number	Annual Premium
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any open Claims? _____
 Please Describe?: _____

FAX THIS FORM TO :

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