Key Risk
a Berkley Company

Human Services

Workers Compensation
Supplemental Application

Employer Name: _____

Website: _____ Phone Number: _____

Primary Contact: _____ Email: _____

Year Established: _____

Description of Operations: _____

_____

Payroll, Premium & Experience Mod History

Please fill in the correct amount for each of the following:

Category	Expiring Year	Prior (1)	Prior (2)	Prior (3)	Prior (4)
Payroll					
Premium					
Experience Mod					

Employer Information

1. Employee Information

Current Number of Employees: _____

Full Time Employees: _____

Part Time Employees: _____

Annual Estimated Turnover Rate: _____

Primary Business Operation (Enter % of operations for all that apply)

_____ % Programs for People with Disabilities

_____ % Child Day Care Programs

_____ % Psychiatric/Mental Health Services

_____ % Crisis/Homeless Services

_____ % Transportation Services

_____ % Programs for Ex-Offenders/ Incarcerated Individuals

_____ % Halfway House

_____ % Goodwill Operations

_____ % Job Assistance/Placement

_____ % Adult or Sr Center Programs

_____ % Home Meal Services

_____ % Programs for Aggressive Adults

_____ % Workshop Operations

_____ % Drug/Alcohol Treatment, Counseling or Detoxification

_____ % Sports/Fitness Facilities

_____ % Home Health/Hospice

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_____ % Group Home/Residential Facilities

_____ % Programs for Aggressive Juveniles

_____ % of Law Enforcement/911 Behavioral Health Intervention Response

_____ % Industries for the Blind

Other: _____

Please indicate where your employees perform their work:

Private Homes/Apartments	_____ %	Nursing Homes	_____ %
Doctors' Offices	_____ %	Corporate Offices	_____ %
Clinical Setting	_____ %	Workshops	_____ %
Secured Facility/Detention	_____ %	Offsite Job Placements	_____ %
Hospitals	_____ %	Animal Stables	_____ %
Community Residences	_____ %		
Other Locations (describe)	_____ %		

Description: _____

Hiring Procedures:

1. Check all methods used prior to hiring employees:

- ☐ Criminal Background Check (Federal)
- ☐ Criminal Background Check (State)
- ☐ Pre-employment/post-offer physicals
- ☐ E-Verify
- ☐ Validate Work History
- ☐ I-9s Obtained for all Employees
- ☐ Verify current certification/licensure/degrees

2. Are volunteers utilized? ☐ Yes ☐ No

3. Are detailed job descriptions available for all positions? ☐ Yes ☐ No

Automobile/Driver Information:

1. Are motor vehicles owned/leased in your operation? ☐ Yes ☐ No

Travel Radius: _____

Describe the type(s) of vehicles and use: _____

Is there an approved driver list? ☐ Yes ☐ No

Who is authorized to operate vehicles? _____

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2. Please indicate the number of drivers who operate:

   Company vehicles? _____ Personal vehicles for company business? _____

3. Are Motor Vehicle Record Checks (MVR) obtained for all drivers of company vehicles? ☐ Yes ☐ No

   If so, how often? _____

4. Are Motor Vehicle Record Checks (MVR) obtained for those operating personal vehicles for company business? ☐ Yes ☐ No

   If so, how often? _____

5. Is a formal vehicle maintenance program in place? ☐ Yes ☐ No

6. Do staff members transport clients in their personal vehicles? ☐ Yes ☐ No

7. Is driver safety training provided? Describe type of training and frequency:

   _____

Risk Management Controls:

1. Is a formal written safety program in place and available to all employees? ☐ Yes ☐ No

   Is there an internal safety inspection program in place? ☐ Yes ☐ No

2. Do you have a designated safety committee? ☐ Yes ☐ No

   If yes, how often does the committee meet? _____

3. Is a formal accident investigation program in place? ☐ Yes ☐ No

4. Is a formal transitional duty program in place to assist in returning injured employee to work? ☐ Yes ☐ No

   If no, would management be willing to put a program in place? ☐ Yes ☐ No

5. Do you have a formal written drug-testing program? ☐ Yes ☐ No

   If yes, check all that apply:

   ☐ Pre-employment/Post-offer ☐ For Cause/Reasonable Suspicion

   ☐ Post-Accident ☐ Random – Percentage _____ %

6. Do you have a physical restraint program? ☐ Yes ☐ No

   If yes, which protocol is implemented and how often is staff recertified?

   _____

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7. Is a formal de-escalation program in place? ☐ Yes ☐ No

If yes, please provide details: _____

8. Is your operation accredited or licensed by any governmental entity or other body? ☐ Yes ☐ No

If yes, please provide the name and type of accreditation or licensure:

_____

9. Is there a Bloodborne Pathogen exposure control plan in place? ☐ Yes ☐ No

General Exposures:

1. % of clients who need assistance with ambulation: _____ % ☐ N/A

2. What type of security is provided for the protection of staff?

☐ Security Cameras ☐ Entry Alarms ☐ Other

3. Indicate if the following are performed by employees or clients:

☐ Janitorial/Maintenance ☐ Landscaping/Mowing ☐ Snow Removal

☐ Power Tools/Machinery ☐ Other: _____

4. Is offsite work at unowned facilities performed? ☐ Yes ☐ No

If yes, please explain: _____

5. Are overnight field trips taken? ☐ Yes ☐ No

If yes, please indicate number per year, usual distance and length of stay: _____

Additional Information

1. Briefly describe program admission criteria:

_____

_____

2. Do you operate a residential facility or group home? ☐ Yes ☐ No

If yes, please complete the Group Home Operations section.

3. Do you operate a workshop? ☐ Yes ☐ No

If yes, please complete the Workshop section.

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Group Home Operations

1.

	Level I	Level II	Level III	Level IV
Percentage	____ %	____ %	____ %	____ %

2.

# of locations by type (residence type, workshop, etc)	Ages Served	Average length of stay

3. Is there a posted emergency evacuation plan? ☐ Yes ☐ No

4. Staff to resident ratio:

Day: _____ Night: _____

Workshop Operations

1. Do the jobs performed involve any of the following exposures? (Check all that apply)

☐ Use of power tools/equipment
☐ Retail operations
☐ Restaurant exposures
☐ Landscaping or lawn care services
☐ Light manufacturing
☐ Refurbishing of donated items
☐ Packaging Services
☐ Other Services*
☐ Janitorial Services

*Other Services _____

2. Does the applicant supply any workers to other employers on a temporary or permanent basis? _____ %

3. Percentage of physically challenged employees/clients: _____ %

4. Does the applicant supply any workers to other employers on a temporary or permanent basis? ☐ Yes ☐ No

5. Is transportation of employees/clients provided to and from work sites? ☐ Yes ☐ No

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6. Are clients thoroughly evaluated and duties matched with abilities prior to job placement? ☐ Yes ☐ No

7. Has the workshop ever been cited for safety deficiencies by any regulatory agencies in the last five years? ☐ Yes ☐ No

Describe any deficiencies noted and corrective actions taken:

8. Additional comments:

Applicant Signature

Notice: This application is for the purpose of obtaining a quotation and does not bind the applicant or the Company to provide the insurance. The Undersigned declares that to the best of his/her knowledge, the statements set forth herein are true. If the information supplied herein changes between the date completed and the effective date of the insurance, the undersigned shall notify the Company of the changes and the Company reserves the right to modify or withdraw any offer for insurance.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other 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 act, which is a crime and may subject such person to criminal and civil penalties.

Applicant Name: _____ Title: _____

Applicant Signature: _____ Date: _____

Phone Number: _____