Breckenridge INSURANCE

Breckenridge Insurance
8985 S. Eastern Ave, Suite 375
Las Vegas, NV 89123

# WC 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: 2020 | | |
| Prior Year: 2019 | | |
| Prior Year: 2018 | | |
| Prior Year: 2017 | | |
| Prior Year: 2016 | | |

**OPERATIONS AND BENEFITS**

| | |
|---|---|
| Broker controlled account? ☐Yes ☐No | |
| Are you a member of the Chamber of Commerce? ☐Yes ☐No | If yes, provide county and membership number: |
| 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: |
| Outside vendor:☐ | |
| In-house mechanics:☐ | |
| Other:☐ | |
| Does insured have and enforce the following policies for drivers:<br>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 no. is consistent w/ no. on ACORD application) | Full | Part | Seasonal | | Volunteers |
| No. of employees per location: | 1. | 2. | 3. | 4. | Use a separate page if needed. |
| No. of W-2s issued: Last Year: _____ Previous Year: _____ | | | Paid sick leave? ☐Yes ☐No | | Paid vacation? ☐Yes ☐No |
| How are employees paid: | Hourly: ☐ | Piece rate: ☐ | Commission: ☐ | Flat Salary: ☐ | Other: ☐ |
| Any day laborers or temporary/employee leasing? ☐Yes ☐No | | | If yes, please provide details on separate page. | | |

| | | |
|---|---|---|
| % of union employees: | %of non-union: | Actual avg. hourly wage for employees in governing class: $_____ |
| 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 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 | 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 | |
| Are personnel files documented for pre-existing injuries? ☐Yes ☐No | Are there set procedures for reporting claims? ☐Yes ☐No | |
| Average claim reporting time frame: | Any interchange of labor? ☐Yes ☐No | |
| Is job specific training provided? ☐Yes ☐No | If yes, please explain: ☐ Another business ☐Subsidiary ☐ Between departments ☐ Other: | |
| 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? Please 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 maximum height at which you will work?_____feet | 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? | Age of building occupied?_____years | |

| 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**):

| | | | |
|---|---|---|---|
| **Must total 100%** 1.) | New Construction: | Remodeling: | Service/Repair: |
| **Must total 100%** 2.) | Commercial: | Apts/Condos/Tract Homes: | Single Custom Homes: |
| **Must total 100%** 3.) | Interior: | Exterior _____ If exterior work done, what is the max. height exposure?_____ | |

| | | | | |
|---|---|---|---|---|
| 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. %

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 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 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_____% | | |

| LANDSCAPING | |
|---|---|
| Any tree trimming performed that is off the ground? ☐Yes ☐No | Any boulder or tree removal performed? ☐Yes ☐No |
| Any use of tractors, loaders or similar equipment? ☐Yes ☐No | Any highway or median work conducted? ☐Yes ☐No |
| Any use of chippers, mulchers, cherry pickers, booms or other similar equipment? ☐Yes ☐No | |
| If yes, please explain. | |
| Any use of pesticides or fertilizers? ☐Yes ☐No | If yes, is the application completed by: ☐Employee ☐Outside vendor |
| Any debris removal or land clearing activities? ☐Yes ☐No | If yes, please explain: |

| MANUFACTURING - MACHINE SHOPS | |
|---|---|
| Any punch press or press brake machinery/equipment? ☐Yes ☐No | Machine Guarded: ☐Point of operation ☐Drive Mechanism |
| Age of machinery: ☐<2 yrs ☐2-5 yrs ☐5-10 yrs ☐10+ yrs | Accessible moving parts guarded on machinery/equipment? ☐Yes ☐No |
| Types of machines (must equal 100%): _____Heavy _____Mid _____Light | Any Computer Network Controlled (CNC) machinery? ☐Yes ☐No |
| Percent of off-premise operations: _____% | If yes, where/what for? |
| Is building properly ventilated? ☐Yes ☐No | Is proper dust collection system in place? ☐Yes ☐No |

Applicant's Signature: _____ Date: _____