

Star Alliance Insurance Services

200 Pine Avenue, Suite 502
Long Beach, CA 90802
Phone: 562-432-8400 FAX: 562-432-8408

Supplemental Workers' Compensation Application

Insured: _____ **E-Mail:** _____ **Policy/App #:** _____

Total Payrolls: \$ 2001 \$ 2000 \$ 1999 \$ 1998

Employee Information

Number of Employees: Full Time _____ Part Time _____ Temporary _____
Governing Code Average Wage \$ _____ Per hour Average Turnover for Last Three Years _____ %
Percentage of Employees with Company over One Year: _____ % Over Three Years: _____ %
Piecemeal based compensation..... Yes - No Drug-Screening (*check those that apply*):
Written Applications used..... Yes - No Pre-employment Random Post Accident
Are References Checked..... Yes - No All-Employees Drivers only None
Pre-employment physicals..... Yes - No Group Medical Coverage Provided..... Yes - No
Employees are unionized..... Yes - No Eligible: All Employees..... Yes - No
Are Seasonal Employees Used..... Yes - No Full Time Employees..... Yes - No
Are Volunteer Laborers Used..... Yes - No Managers and Supervisors... Yes - No
Are Leased Employees Used..... Yes - No
Formal Employee Training Portion paid by employer..... _____ %
 New Employee Training..... Yes - No Waiting Period for Coverage..... _____ Days
 Employees with new assignments... Yes - No Paid Sick Leave..... Yes - No
Does Insured have a formal Paid Vacation..... Yes - No
 Early Return To Work program? Yes - No Retirement/401K Plan..... Yes - No

Management and Safety Practices

Majority of Owners Active in Management..... Yes - No
Formal Safety Program Yes - No
Safety Meetings Held Yes - No Weekly Monthly Quarterly Other _____
Attendance Mandatory for all employees..... Yes - No
Safety Committee..... Yes - No Composed of Management Supervisors Workers
Safety Director..... Yes - No Full Time Part Time - Experience _____ Years
Safety Inspections..... Yes - No Daily Weekly Monthly Other _____
Facility Inspection Checklist Used..... Yes - No Completed by: _____
Loss Control Incentive Program Yes - No Method _____
Employee Communication Program..... Yes - No Written Disciplinary Procedure..... Yes - No
Are Supervisors/Foremen Accountable for Safety . Yes - No By Foremen Safety Director Owner Other
Accident Investigation..... Yes - No
Exit Interviews..... Yes - No N/A
All Machinery Properly Guarded..... Yes - No Maximum Manual Lifting _____ Pounds
Lock Out / Tag Out Procedures..... Yes - No Description _____
Mechanical Lifting Devices..... Yes - No N/A
Forklift Operators Certified..... Yes - No Description _____
Personal Protective Equipment Use Enforced..... Yes - No Employees Trained in First Aid..... Yes - No
In House First Aid Facilities..... Yes - No Physician Clinic Other
Designated Medical Provider..... Yes - No
Has Medical Provider Reviewed Operations to Assist with Early Return to Work Program? Yes - No
Describe Housekeeping Excellent Above Average Average Below Average Poor
Number of Company vehicles _____ Delivery Provided Yes - No
Number of Company authorized drivers _____ Driver training provided Yes - No
Radius of Travel for Company Vehicles _____ Miles *If yes how often* _____
MVRs Checked..... Yes - No Participate in DMV "Pull" Program.... Yes - No
Vehicle and Equipment Inspected Daily Weekly Monthly
Vehicles and Equipment Serviced By..... Employees Outside Mechanics

IMPORTANT NOTICE: The information provided on this Supplemental Workers' Compensation Application will be used in determining applicable credits and/or debits. In those instances where further explanation is relevant please do not hesitate to provide additional narrative on a separate sheet.