Staffing LINES
THE WORKERS' COMPENSATION AUTHORITY

Staffing Workers' Compensation Supplemental Questionnaire

APPLICATION INFORMATION

Insured Name:	Agency Name:
Insured Main Contact:	Broker Contact:
Insured Email:	ASA Member: ❑ Yes ❑ No
Insured Phone #:	# of Physical Locations (must be on Acord):
Years in Business:	Proposed Effective Date:

Prior Coverage Information

	Current Year	Prior Year 1	Prior Year 2	Prior Year 3	Prior Year 4
Premium (Audited)					
Payroll (Audited)					
Carrier					
Experience Mod					

Operations Overview

Category	Percentage	Description
Temporary Help	%	Placements that support or supplement a client's workforce for a limited time
Day Labor	%	Unskilled labor paid by the day – can include daily transportation to job site
Long-Term Staffing	%	Assignments that last 6 months or longer
Temp. to Perm.	%	Temporary assignments with the expectation that the employee will be hired by the client on a permanent basis
Payrolling	%	Carries another entity's employees on the above insured's payroll
PEO/Emp. Leasing	%	Employees are employed by above insured who also handles all HR-related functions, but the employee actually performs all work for the client company (co-employment)

Client Information

# of Active Clients:	Average # of New Clients Annually:
# of W2s (last calendar year):	# of 1099s (last calendar year):
# of Full-time Office Staff:	If 1099s, is payroll included for the workers' comp or are they required to carry their own coverage? ❑ Included ❑ Carry ❑ Own
% of exposure in LA County (California):	% of exposure in the 5 boroughs (New York):

Client Breakdown

	% of Exposure	Avg. Hourly Wage		% of Exposure	Avg. Hourly Wage
Clerical	%		Professional	%	
Light Manufacturing	%		Retail/Wholesale	%	
Heavy Manufacturing	%		Warehouse	%	
Construction/Contracting	%		Transportation	%	
Healthcare	%		Hospitality	%	

Other (please specify): _____ %

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Top 5 Clients				
Client Name	**Desc. of Operations/Temps' Job Duties**	**Class Code**	**Payroll**	**# of Temps**

RISK MANAGEMENT

Client Screening		
		Details (if yes, details must be provided)
Established Client Selection Criteria?	❑ Yes ❑ No	
Job Site Inspections? (provide copy of template)	❑ Yes ❑ No	
OSHA Log/Mod Reviewed?	❑ Yes ❑ No	
Procedures for Terminating Poor Performing Clients?	❑ Yes ❑ No	
Formal Safety Training Performed by the Client?	❑ Yes ❑ No	

Safety Program		
		Details (if yes, details must be provided)
Full-time Safety Director (provide name, title & duties)?	❑ Yes ❑ No	
Written Safety Plan?	❑ Yes ❑ No	
Safety Committee?	❑ Yes ❑ No	
Supply Safety Equipment Needed? (what?)	❑ Yes ❑ No	
Safety Training Provided?	❑ Yes ❑ No	
Forklift Certification?	❑ Yes ❑ No	
Written Return to Work Program? (provide copy)	❑ Yes ❑ No	
Safety Incentive Program?	❑ Yes ❑ No	
Are Recruiters Accountable for Safety Results at Clients' Locations?	❑ Yes ❑ No	
Onsite Supervisors Provided to Clients?	❑ Yes ❑ No	
Physical Requirements for All Non-clerical Job Assignments?	❑ Yes ❑ No	

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Claims Management		
		Details (if yes, details must be provided)
Full-time Claims Manager? (provide name & title)	❑ Yes ❑ No	
Accident Investigation? (provide template copy)	❑ Yes ❑ No	
Drug Testing After Loss?	❑ Yes ❑ No	
Results Tracked by Client?	❑ Yes ❑ No	
Claims Reviews with Clients? (How frequently?)	❑ Yes ❑ No	
Fraud Investigation Process?	❑ Yes ❑ No	
Established Injury Reporting Procedures? (provide copy)	❑ Yes ❑ No	
Claims Reported within 24 Hours?	❑ Yes ❑ No	
Does Timecard Have Disclaimer About Injury? (provide copy)	❑ Yes ❑ No	

HUMAN RESOURCES

Employee Screening		
Pre-screening: ❑ Yes ❑ No	Signed Application: ❑ Yes ❑ No	Resume: ❑ Yes ❑ No
Interview: ❑ Yes ❑ No	Skills Testing: ❑ Yes ❑ No	I-9 Verification/e-verify: ❑ Yes ❑ No
100% Drug Testing: ❑ Yes ❑ No	By Client Request Drug Testing: ❑ Yes ❑ No	Reference Checks: ❑ Yes ❑ No
MVR Checks: ❑ Yes ❑ No	Criminal Background Checks: ❑ Yes ❑ No	Probationary Period: ❑ Yes ❑ No
Physicals: ❑ Yes ❑ No	Minimum Experience Required: ❑ Yes ❑ No	Personality Assessment: ❑ Yes ❑ No

Employee Benefits for TEMPORARY Employees Only		
		Details (if yes, details must be provided)
Medical Benefits? (provide carrier name)	❑ Yes ❑ No	
Employee Contribution?	❑ Yes ❑ No	
Paid Time Off (how is it accumulated?)	❑ Yes ❑ No	
Paid Holidays?	❑ Yes ❑ No	
Paid Sick Days?	❑ Yes ❑ No	

General Questions		
		Details (if yes, details must be provided)
Any Audit Problems or Disputes?	❑ Yes ❑ No	
Any Cancellation for Nonpayment?	❑ Yes ❑ No	

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General Questions		
Any Group Transportation?	❑ Yes ❑ No	
Any Employees Placed or Travel Outside the U.S.?	❑ Yes ❑ No	
Any USL&H, FELA or Defense Base Act Coverage Needed?	❑ Yes ❑ No	
Any Other Commonly Owned Operations?	❑ Yes ❑ No	
Are 50 or More Employees at the Same Client Location at One Time? (provide client list)	❑ Yes ❑ No	

HEALTHCARE STAFFING
(COMPLETE ONLY IF MAKING HEALTHCARE PLACEMENTS)

Environment in Which Healthcare Staffing Is Done (Please provide % of payroll for each that apply. Must total 100%)		
Hospital: %	Nursing/Asst. Living Home: %	Psychiatric Facility: %
Private Homes: %	Doctor's Office: %	Dental Office: %
Prison: %	Manufacturing Facility: %	School: %
Other (please describe): % _____		

Percentage of Placements in the Following Occupations (Must total 100%)		
RNs: %	LPNs: %	CNAs: %
Physician's Assistants: %	Homemaker/Home Aid: %	Lab Techs: %
Social Workers: %	Physical Therapists: %	Infusion Therapists: %
Speech Therapists: %	Occupational Therapists: %	Doctors/Dentists: %
Other (please describe): % _____		

Does the insured provide traveling nurses?	❑ Yes ❑ No
Do the employees leave the state in which insured is headquartered?	❑ Yes ❑ No
If yes, are all states listed on the Acord with payroll?	❑ Yes ❑ No
Does the insured provide housekeeping personnel to any medical facility?	❑ Yes ❑ No

Does the Insured Have a Written Safety Program That Includes the Following?	
OSHA Bloodborne Pathogens standard?	❑ Yes ❑ No
Personal Protective Equipment requirements?	❑ Yes ❑ No
OSHA Needlestick Safety and Prevention?	❑ Yes ❑ No
Is the Hepatitis B vaccine series offered?	❑ Yes ❑ No
Does the insured have a written hazard communication policy?	❑ Yes ❑ No

Are Employees Required to Lift or Physically Transfer Patients?
❑ Yes ❑ No
If so, describe safety training and company procedures for safe lifting: _____

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What is the % breakdown between ambulatory vs. non-ambulatory patients?	
Ambulatory Patients	**Non-Ambulatory Patients**
%	%

By signing, we agree that all information included in this supplemental application is accurate at the time of completion and signature. We understand that if coverage is obtained based on this information and it is found to be inaccurate that coverage may be cancelled.

Producer Name: _____ Date: _____

Producer Signature: _____

Insured Name: _____ Date: _____

Insured Signature: _____