RISK INNOVATIONS®
A JENCAP® COMPANY

Temporary Staffing Supplemental Application

Employer Name: _____

Employer Primary Contact: _____ Phone: _____

Email: _____ Website: _____

Descriptions of Operations: _____

_____

Premium, Payroll and Experience Mod History

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

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

General Applicant Information

1. What is the percentage of your anticipated annual growth for the upcoming year? _____
   Details: _____
2. Are you a new Venture? *(If yes, attach all Sr. Executive resumes' and your Pro Forma Balance Sheet prepared by an accountant.)* ☐ Yes ☐ No
3. Have you conducted business in your present territory for at least 3 years? (If no, provide details.) ☐ Yes ☐ No
   Details: _____
4. Do you provide any assignments that are not temporary in nature (i.e. that do not have an end date)? ☐ Yes ☐ No
   If yes, explain: _____
5. Are you required to be licensed or register as a PEO (Professional Employer Organization) in any of the states in which you operate? ☐ Yes ☐ No
6. Do you provide any PEO services? ☐ Yes ☐ No
   If yes, explain: _____
7. Are there any other commonly owned businesses that are separately insured? ☐ Yes ☐ No
   If yes, explain: _____
8. Are there any states in which you operate that are covered elsewhere? ☐ Yes ☐ No
   If yes, explain: _____
9. Do you hire day laborers? ☐ Yes ☐ No
10. Do you provide group transportation? ☐ Yes ☐ No
11. Do you employ 100 or more workers at any single work location? ☐ Yes ☐ No

12. Do you have any outstanding WC premium or audit issues from the last three policy terms? ☐ Yes ☐ No
If yes, explain: _____

13. Do you supply workers to construction operations in California? ☐ Yes ☐ No

14. Do any of your clients have exposures to Maritime operations subject to the USL&H Act, the Admiralty Law or the Outer Continental Shelf Lands Act? ☐ Yes ☐ No
If yes, explain: _____

15. Do any of your clients have exposures to the following Acts: Migrant and Seasonal Agricultural Worker Protection Act, Federal Employers' Liability Act, Federal Coal Mine Health & Safety Act, Defense Base Act? ☐ Yes ☐ No
If yes, explain: _____

16. Are you requesting Employer's Liability ("Stop Gap") in any of the following states: ND, OH, WA and WY? ☐ Yes ☐ No
If yes, provide annual premium for each state: _____

17. Do you have foreign travel exposures?
If yes, provide details concerning countries, duration, and number of employees: _____ ☐ Yes ☐ No

18. Do you accept other temporary staffing agencies as clients (i.e. piggyback arrangements)? ☐ Yes ☐ No
If yes, provide details and payroll associated with these clients: _____

Employee Screening

Does your New Hire Program include the following:		Details:
1. Formal written job application	☐ Yes ☐ No	
2. Criminal Background Checks	☐ Yes ☐ No	
3. Reference checks	☐ Yes ☐ No	
4. Motor Vehicle checks on drivers	☐ Yes ☐ No	
5. Job experience & placement certification requirements	☐ Yes ☐ No	
6. Pre-employment physicals	☐ Yes ☐ No	
7. Pre-employment drug testing	☐ Yes ☐ No	
8. Probationary period	☐ Yes ☐ No	
9. Minimum Experience Requirements	☐ Yes ☐ No	
10. Any additional information. If yes, provide details.	☐ Yes ☐ No	

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Employee Benefits

Does your Employee Benefits Program include the following:		Details:
1. Health Insurance	☐ Yes ☐ No	
2. Long-Term Disability	☐ Yes ☐ No	
3. Short-Term Disability	☐ Yes ☐ No	
4. Paid Vacation Days	☐ Yes ☐ No	
5. Paid Sick Days	☐ Yes ☐ No	
6. Employee Assistance Program	☐ Yes ☐ No	

Client Information

Average Number of New Clients added annually?: _____

Client Exposure Breakdown *(List the number of clients and the total number of employees you have for each industry.)*

	# of Clients	# of Employees
Light Industrial:		
Heavy Industrial:		
Construction (Trade):		
Construction (General):		
Wholesale / Retail:		
Clerical (Professional):		
Clerical (General):		
Medical:		

Total # of Full-Time Office Staff: _____

Total # of Temporary Placements Last Year: _____

# of W2's: _____ # 1099's: _____

Do you require independent contractors to carry their own workers compensation coverage? ☐ Yes ☐ No

If no, please explain reasoning: _____

Profile of the Five Clients with the Highest Number of Employees You Provide:

Customer Name	Description of work performed by your employees	Class Code	State	Payroll	Clients # of Employees	# of Temp

Client Screening

		Details:
1.	Do you have established criteria for new client selection? If yes, provide details. ☐ Yes ☐ No	
2.	Do you complete job hazard assessments for all new clients or new tasks? If yes, provide details. ☐ Yes ☐ No	
3.	Do you have procedures in place to eliminate clients for poor safety practices or loss experience? ☐ Yes ☐ No	
4.	Do you review the client's new worker orientation procedure? ☐ Yes ☐ No	
5.	Do you review client's response procedures for emergency or accidents? ☐ Yes ☐ No	
6.	Do you inspect worksites for safety "prior' to employee placement? *(If yes, please provide inspection template.)* ☐ Yes ☐ No	
7.	Do you or the client provided employees with a description of the job assignment? ☐ Yes ☐ No	
8.	Do you or the client provide safety training? If yes, provide details. ☐ Yes ☐ No	

Safety Management By Applicant

Does your Safety program include the following:		Details:
1.	Written Safety Plan? *(If yes, please provide table of contents.)* ☐ Yes ☐ No	
2.	Full time safety director? If yes, provide name, title and duties. ☐ Yes ☐ No	
3.	Safety committee? ☐ Yes ☐ No	
4.	Accident investigation? ☐ Yes ☐ No	
5.	Employer provided safety equipment? ☐ Yes ☐ No	
6.	Employee training for lifting, ergonomics, universal precautions? ☐ Yes ☐ No	

7.	Employee safety meetings?	☐ Yes ☐ No	
8.	Loss Control/Safety incentives?	☐ Yes ☐ No	
9.	Light duty / early return to work program? *(If yes, pelase provide a copy.)*	☐ Yes ☐ No	
10.	Random drug testing program	☐ Yes ☐ No	

Claims Management And Reporting

Does your Claims Management program include the following:			Details:
1.	Full time claims manager	☐ Yes ☐ No	
2.	Claims fraud investigator	☐ Yes ☐ No	
3.	Established injury reporting procedures	☐ Yes ☐ No	
4.	Require all WC claims to be reported within 24 hrs.	☐ Yes ☐ No	
5.	Drug testing after an injury occurs. If yes, provide details on procedure.	☐ Yes ☐ No	
6.	A process to identify claims frequency and claims trends	☐ Yes ☐ No	
7.	Mid term monitoring and reporting of trends in claim frequency and severity	☐ Yes ☐ No	

Healthcare Staffing *(Complete only if making Healthcare placements.)*

1. Please provide the percentage (%) of payroll for the environments in which Healthcare Staffing is conducted:

0.00%	Dental Office	0.00%	Doctor's Office	0.00%	Hospitals
0.00%	Manufacturing Facility	0.00%	Nursing/Assisted Living Home	0.00%	Prison
0.00%	Private Homes	0.00%	Psychiatric Facility	0.00%	School
0.00%	Other *(Please Specify):*				

2. Percentage (%) of placements in the following occupations:

0.00%	RNs	0.00%	LPNs	0.00%	CNAs
0.00%	Doctor/Dentis	0.00%	Homemaker/Home Aid	0.00%	Infusion Therapist
0.00%	Lab Techs	0.00%	Occupational Therapist	0.00%	Physical Therapist
0.00%	Physician's Assistant	0.00%	Social Worker	0.00%	Speech Therapist
0.00%	Other *(Please Specify):*				

3. Do you provide traveling nurses? ☐ Yes ☐ No

   Do the employees leave the state you are headquartered in? ☐ Yes ☐ No

   If yes, are all states listed on the ACORD with payroll? ☐ Yes ☐ No

4. Does the written safety program include the following?

OSHA Bloodborne Pathogens	☐ Yes ☐ No	Hepatits B Vaccine Services Offered	☐ Yes ☐ No
Personal Protective Equipment Requirements	☐ Yes ☐ No	OSHA Needlestick Safety and Prevention	☐ Yes ☐ No

5. Do you conduct pre-placement physical exams on all prospective hires involved in patient or client care? ☐ Yes ☐ No

6. Are employees required to lift or physically transfer patients? ☐ Yes ☐ No

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: _____

Applicant Signature: _____ **Date:** _____

Producer Signature: _____ **Date:** _____