WCF WORKERS COMPENSATION FUND

GENERAL BUSINESS SUPPLEMENTAL QUESTIONNAIRE

INSTRUCTIONS

1. Please complete all sections.
2. If you have questions while completing the questionnaire, call (801) 288-8579 or (801) 288-8281 or toll free (800) 446-2667 ext. 8579 or ext. 8281.
3. Return the completed questionnaire to WCF either by fax or mail.

Fax (801) 288-8166
Workers Compensation Fund
Attn: Underwriting Department
392 East 6400 South
Salt Lake City, Utah 84107

COMPANY _____ DATE _____

COMPANY CONTACT PERSON _____ TITLE _____ POLICY NUMBER _____

WCF AGENT OR MARKETING REPRESENTATIVE _____ INTERNET WEBSITE ADDRESS _____

PHYSICAL LOCATION

DESCRIPTION OF OPERATIONS (i.e. products/services, processes utilized, distribution, work at heights, etc.):

_____
_____
_____
_____

List any operation changes during the past year:

_____
_____
_____
_____

EMPLOYEE LEASING OR STAFFING OPERATIONS (Check all that apply.)

☐ Own or Operate a Leasing or Staffing Company ☐ Lease Employees

MEDICAL MANAGEMENT (Check all that apply.)

☐ Utilize WCF Preferred Provider Network ☐ First Aid Kits

☐ Employee First Aid/CPR Training ☐ Early Return to Work Program

SAFETY DEVICES (Check all that apply.)

☐ Personal Protective Equipment — List equipment used.

_____
_____
_____

☐ Personal Protective Equipment Required and Enforced

_____
_____
_____

☐ Company Vehicles — List vehicles used.

_____
_____
_____

☐ Motor Vehicle Records Checked ☐ Pre-hire ☐ Quarterly ☐ Bi-Annually ☐ Annually

☐ Mandatory Seat Belt Policy ☐ Scheduled Maintenance Program ☐ Defensive Driving Training Program

(Over - Complete Reverse Side)

EMPLOYEES SELECTION, TRAINING, SUPERVISION (Check all that apply.)

Total Number of Current Employees: _____ Number of W-2's Last Year: _____

Total Number of Shifts: _____ Number of Employees per Shift: _____

☐ Employment Application	☐ Personal Interviews	☐ References Verification	☐ Drug/Alcohol Program
☐ Pre-hire Drug Testing	☐ Random Drug Testing	☐ For Cause Drug Testing	☐ Post Accident Drug Testing
☐ Medical Benefits	☐ Long-Term Disability	☐ Short-Term Disability	☐ Union Shop
☐ New Employee Safety Training	☐ Documented Safety Meetings	☐ Safety Incentives/Contests	☐ Discipline Program

MANAGEMENT SAFETY ORGANIZATION (Check all that apply.)

☐ Safety Director	Name of Safety Director: _____	☐ Safety Committee
☐ Fleet Director	Fleet Director Name: _____	☐ Scaffold Safety Program
☐ Hazard Communication Program	☐ Written Safety Program	☐ Forklift Certification Program
☐ Confined Spaces Program	☐ Hearing Protection Program	☐ Blood-Borne Pathogens Program
☐ Respiratory Protection Program	☐ Fall Protection Program	☐ Lock Out/Tag Out Program
☐ OSHA 300 Log	☐ Accident Investigation	☐ Crane Safety Program

LOSS INFORMATION (Please list most common injuries and preventive measure(s) you have taken in the space below.)

_____
_____
_____
_____
_____
_____
_____
_____
_____

PRINT NAME	SIGNATURE OF OWNER, PARTNER OR CORPORATE OFFICER	DATE

For your protection, Utah law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in the state prison.

Workers Compensation Fund

Application for Utah Workers Compensation and Employers Liability Insurance

Please print or type

1. Business Name

Give Exact and Full Name	Years in Business

2. Mailing Address

Street or P. O. Box			Business Telephone No.
City	State	Zip Code	Fax No.
E-Mail Address of Workers Compensation Contact			

3. Payroll Record / Location (Payroll Audit) / Check if Same as Mailing Address ☐

Street or Location Description			Payroll Telephone No.
City	State	Zip Code	Name of Person to Contact

4. Nature of Business / Description of Operations

5. Ownership Information

Type of Ownership:

Federal Tax ID No.

☐ 1. Sole Proprietor ☐ 2. Partnership ☐ 3. Corporation
☐ 4. Joint Venture ☐ 5. Limited Liability Co. ☐ 6. Association
☐ 7. Limited Partnership ☐ 8. Government ☐ 9. Other _____

Note: A partnership or sole proprietorship may elect to include as an employee any partner of the partnership or the owner of the sole proprietorship. For premium computation purposes, the salary or wage of partners or sole proprietors shall be 100% of the state average weekly wage. A corporation may elect not to include any director or officer of the corporation as an employee.

List Below Complete Information for: 1. Sole Proprietor 2. Partners 3. Corporate Officers

Name (Last, First, Middle Initial)	Title	% of Ownership	Social Security No.	Coverage Desired? (Yes / No)	Principle Duties

6. Previous Insurance Coverage? ☐ No ☐ Yes (If yes, provide information below for last 3 years)

Policy Period from (MO / YR) to (MO / YR)	Insurance Company Name	Annual Premium	Experience Modifier	Claims Cost, including Reserves

7. Names (including DBA's) and Street Addresses of all Utah Locations (use additional page if necessary)

	Name	Street or Location	City	Zip Code
1.				
2.				
3.				

8. Work Classifications and Estimated Annual Payroll by Location

	By Location, List Duties of Employees including Covered Corporate Officers by Type of Work Performed. Do Not Include Earnings of Partners or Sole Proprietor.	No. of Employees	Estimated Total Annual Payroll	WCF Use Only: Class Codes	Rate	Estimated Premium
1.						
2.						
3.						
4.						

9. Employers Liability Insurance

Employers Liability Insurance Provides Coverage Against Lawsuits Brought by an Employee Against the Employer for On-the-Job Injuries.

Standard Limits for the Policy are:

Bodily Injury by Accident	(Each Accident)	$100,000
Bodily Injury by Disease	(Policy Limit)	$500,000
Bodily Injury by Disease	(Each Employee)	$100,000

If higher limits are desired, please contact the Underwriting Department for available options and costs.

WCF Use Only

Total Estimated Manual Premium	
Increased Liability Limits	
E-Mod Factor	
Scheduled Credit / Debit Factor	
Premium Size Discount	
Estimated Annual Premium	
Down Payment	
Effective Date	
Number Assigned	

WCF Use Only

Payment Plan:	Underwriter:	
Agency Name	Agency Code No.	Producer

10. General Information (Explain "Yes" Answers in the Remarks Section Below)

Questions	Yes	No	Questions	Yes	No
1. Does applicant own, operate or lease aircraft / watercraft?			10. Are athletic teams sponsored?		
2. Do / have past, present or discontinued operations involve(d) storing, treating, discharging, applying, disposing or transporting hazardous material?			11. Any prior coverage declined, cancelled or non-renewed within the last 3 years?		
3. Any work performed underground or above 15 feet?			12. Are employee health plans provided?		
4. Is applicant engaged in any other type of business?			13. Is there a labor interchange with any other business / subsidiary?		
5. Are sub-contractors used? If "yes", give % of work sub-contracted.			14. Do you lease employees to or from other employers?		
6. Any work sublet without certificates of insurance?			15. Do any employees predominantly work at home?		
7. Is a written safety program in operation?			16. Any tax liens or bankruptcy within the last 5 years?		
8. Any group transportation provided?			17. Any undisputed and unpaid workers compensation premium due from you or any commonly managed or owned enterprises? If "yes", explain including entity name(s) and policy number(s).		
9. Do employees travel out-of-state?					

Remarks

Individual to Contact if Additional Information is Needed

Name	Phone No.

It is agreed that contractors and sub-contractors engaged by the applicant who cannot provide a Certificate of Workers Compensation Insurance substantiating an active workers compensation policy shall be included in the applicant's payroll and premium paid by the applicant.

Upon receipt of the completed and signed application, the Workers Compensation Fund will provide the applicant with a proposal showing the classifications, rates and deposit required. In order to initiate coverage, applicant must return one copy of the proposal with the required payment to the Workers Compensation Fund.

Coverage will be effective at 12:01 a.m. on the date following receipt of one copy of the signed proposal and required payment by Workers Compensation Fund.

Print or Type Name and Title of Owner, Partner or Corporate Officer	Signature of Owner, Partner or Corporate Officer	Date

Please return completed and signed application to:

Workers Compensation Fund
P. O. Box 57929
Salt Lake City, UT 84157-0929

If you have any questions, please call (801) 288-8020.

For your protection, Utah law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in the state prison.

WCF 1001-3 (Rev. 5/06)

ADDITIONAL SAFETY QUESTIONS

Company Name:
Policy Number:

1. If and what fall protection do you use? Other safety precautions?

2. Is the above enforced? If so, how?

3. What are your hiring practices?

4. Employment turnover rate. Explain.

5. What type of supervision do your employees have?

6. Are owners of the company on job sites?

7. Do you have an early return to work program with modified duty? Describe.

Signature:_____

Date:_____