RT WC Specialty

Healthcare

Supplemental Workers' Compensation Application

Insured Name: ____

Insured Web Address: ____

Insured FEIN: ____

Payroll/Premium Information:

Policy Year	Payroll	Premium
4th Prior	$	$
3rd Prior	$	$
2nd Prior	$	$
1st Prior	$	$
Current	$	$

Applicant Overview:

1. Does common ownership (over 50%) exist with any other operations? ☐ Yes ☐ No

2. Any group transportation of employees? ☐ Yes ☐ No

3. Radius of operations: ☐ <25 miles ☐ 25-50 miles ☐ 50+ miles

If Yes, provide names & types of operations:

Date business established: ________________________________ Number of years under current ownership: ______________

☐ For Profit ☐ Not for Profit ☐ Partnership ☐ Other: ___________________________________

Total Number of Employees: ___________________ W-2: _______________________ 1099: _________________________________

Employee Annual Turnover Rate: ________% Total Number of Full Time Employees: ___________________________

Total Number of Part-time Employees: _______________ Total Number of Volunteers: ___________________________________

Does the Applicant have a Skilled Nursing Facility? ☐ Yes ☐ No

Business Operations (Check all that apply):

☐ Home Health ☐ Substance Abuse Counseling ☐ Assisted Living ☐ Nursing Home

☐ Personal Care Provider ☐ Mental Health Counseling ☐ Hospice

Please indicate where your employees perform their work:

Private Homes ______% Clinics ______% Nursing Homes ____% Hospitals ______%

Corporate Offices ______% Doctor's Office ______% Community Residence ______% Other Locations ______%

Please specify if other:

1. What percentage of employees are Registered Nurses?

   ☐ 0 to 25% ☐ 25 to 50% ☐ 50 to 75% ☐ 75 to 100%

2. What percentage of employees are Certified Nursing Assistants?

   ☐ 0 to 25% ☐ 25 to 50% ☐ 50 to 75% ☐ 75 to 100%

3. Is insured part of a public or government agency? ☐ Yes ☐ No
4. Is insured certified by Medicare? ☐ Yes ☐ No
5. Percentage of Medicare/Medicaid clients?

   ☐ 0 to 25% ☐ 25 to 50% ☐ 50 to 75% ☐ 75 to 100%

6. Percentage of private pay clients?

   ☐ 0 to 25% ☐ 25 to 50% ☐ 50 to 75% ☐ 75 to 100%

7. Do employees primarily cook, clean, bathe, groom, or perform general housekeeping activities? ☐ Yes ☐ No
8. Does insured provide live in 24-hour home healthcare workers? ☐ Yes ☐ No
9. What is average length of shifts? _________ hrs
10. Do the employer lease employees or utilize a staffing company? ☐ Yes ☐ No
11. Are 1099's used? ☐ Yes ☐ No

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12. Do employees drive personal vehicles? ☐ Yes ☐ No
13. Do employees drive company vehicles? ☐ Yes ☐ No
14. Average radius employees drive during workday? _________________ miles
15. Are Motor Vehicle Records (MVR) checked annually for all employees who drive as part of their job? ☐ Yes ☐ No
16. Do you have written MVR standards for your employees? ☐ Yes ☐ No

    Please clarify the following:

    MVRs verified at time of hire. ☐ Yes ☐ No

    Copies of MVR's maintained in personnel files? ☐ Yes ☐ No
17. Are crime statistics reviewed prior to sending employees to a residential location? ☐ Yes ☐ No
18. Is there a formal safety program in place that addresses blood born pathogens, chemical hazards, disease, driver safety, lifting, latex allergies, violent behavior, infection control, proper use of medical equipment, SHARPS disposal, etc.?

    ☐ Yes ☐ No
19. Are employees provided with the proper equipment for individual patient care? ☐ Yes ☐ No
20. Are documented proper procedures for safe lifting provided to employees? ☐ Yes ☐ No
21. Is there a formal return to work/modified duty program in place? ☐ Yes ☐ No
22. Are pre-employment medical exams completed? ☐ Yes ☐ No
23. Is there a formal pre-hire drug testing program in place? ☐ Yes ☐ No
24. Is a formal post accident drug testing program in place? ☐ Yes ☐ No

Covid-19 Questionnaire

How many employees have tested positive for COVID-19? ____

When was the last positive test? ____

Have any employees died from COVID-19? ☐ Yes ☐ No

If Yes, how many? ____

What are the COVID-19 screening protocols for employees daily? ____

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What are the quarantine protocols if an employee is experiencing symptoms or has been exposed to COVID-19?

What safety protocols have been implemented in response to COVID-19 and when were the protocols implemented?

Is there an assigned COVID-19 safety coordinator? ☐ Yes ☐ No

If Yes, please provide name & title: ______________________________

Is PPE provided to employees to help protect against COVID-19? ☐ Yes ☐ No

Please specify what PPE is used: ______________________________

If Long-Term Facility, please answer the following:

Are employees tested for COVID-19 regularly? ☐ Yes ☐ No

If so, how often? ______________________________

Is there currently a "no visitor" policy in place? ☐ Yes ☐ No

If so, when was this policy enacted? ______________________________

If a patient/resident tests positive for COVID-19, what are the quarantine protocols?

How many patients/residents have died from COVID-19? ______________________________

If Home Health Agency, please answer the following:

Do employees screen clients for COVID-19 symptoms? ☐ Yes ☐ No

Explain process:

Will employees be allowed to enter the residences of clients that are COVID-19 positive? ☐ Yes ☐ No

If Yes, explain:

The undersigned attests that all information provided is both accurate and truthful. All information provided is subject to verification by way of an underwriting survey or inspection. You must notify RT Specialty of any significant change in operations or payroll. Terms of insurance coverage may be canceled for misrepresentation if information provided is inaccurate.

Signature of Applicant: ____

Title: ____

Print Name: ____ Date: ______________

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