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 CA# 0334819

# Workers Compensation Supplemental Application

**General Information** Current number of seasonal employees: \_\_\_\_\_

Percent of employee turnover in the last 12 months: Full time: \_\_\_\_\_ Part time: \_\_\_\_\_

If California, please provide the zip code with the highest exposure: \_\_\_\_\_

**Benefits** Group medical insurance? Yes  No  What percentage of employees are covered by the plan? \_\_\_\_\_%

Who is eligible? All employees  Only full time  Other:  \_\_\_\_\_ CPR training provided? Yes  No

**Hiring Practices** Check all that apply:

- Audio Testing
- Orthopedic Back Test
- Reference Check
- Validate Work History
- Criminal Background Check
- Pre/Post Employment Physical
- Substance Abuse Testing
- Written Application
- Formal Interview

Are written job descriptions provided? Yes  No

**Safety** Designated full time safety director? Yes  No  Name: \_\_\_\_\_

Do you have a designated safety committee? Yes  No  Meeting frequency: Daily  Weekly  Monthly  Annually

Does the safety committee present their findings to a management team? Yes  No

What is reviewed by the safety committee during their meetings? \_\_\_\_\_

Safety meetings held for all employees? Yes  No  Frequency: \_\_\_\_\_

Safety training program in place for employees? Yes  No

Safety incentive program? Yes  No  What is the incentive? \_\_\_\_\_

Slip & Fall prevention program? Yes  No  Proper lifting program? Yes  No

Personal protective safety equipment provided? Yes  No

Equipment safeguards utilized? Yes  No  Equipment inspection/maintenance program? Yes  No

If yes, describe: \_\_\_\_\_

Hazardous materials communication program? Yes  No  Accident investigation program? Yes  No

Are supervisors held accountable for injuries? Yes  No

**Management** Does the insured have a return to work program? Yes  No  With full pay? Yes  No

Written  Informal  Modified duty offered to injured employees? Yes  No

Is the insured willing to implement safety recommendations made by the carrier? Yes  No

Is the insured willing to implement loss control recommendations made by the carrier? Yes  No

**Premises** Housekeeping/cleanliness at the jobsite Excellent  Good  Poor

Condition of equipment: Excellent  Good  Poor  Proper safeguards? Yes  No

Do employees perform maintenance and custodial work at your facilities? Yes  No

If yes, are the employees responsible for housecleaning, laundry, cooking or yard work/landscaping? Yes  No

If yes, do employees maintain the exterior?

**Vehicle/Driving Exposure** Is there a driver safety program? Yes  No  Are MVR's run? Yes  No

How often?: \_\_\_\_\_ Describe MVR acceptability criteria and procedures for dealing with unacceptable drivers and violations: \_\_\_\_\_

Driving distance? \_\_\_\_\_ Frequency of driving? Daily  Weekly  Other  \_\_\_\_\_

Number of company vehicles? \_\_\_\_\_ Number of employees authorized to operate company vehicles? \_\_\_\_\_

What is the purpose of the driving exposure? \_\_\_\_\_

Do more than 3 employees travel together in any one vehicle? Yes  No

Vehicles inspection/maintenance program? Yes  No