

Section 8 – Was this operation all or part of an existing business that was purchased or acquired? <input type="checkbox"/> Yes <input type="checkbox"/> No, skip to Section 9	
What percentage of the business was acquired?: _____	Date ownership changed: _____
Prior business owner's name and address: Name: _____ Address: _____ Name of Business: _____	
Is the prior owner(s) related to the new owner(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Relationship: _____	
Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____	
Were more than 50% of the current employees hired since the acquisition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are those new employees earning more than 50% of the payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 9 – Management Practices

Please indicate if you offer: Employee Assistance Program ___ Paid Vacations ___ Paid Sick Leave ___	
Do you have a minimum of 2 employees? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, do you pay at least 50% of the Health Insurance premium? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Health Insurance Carrier: _____	
Please check off the hiring practices implemented by your company: Job Descriptions ___ Pre-placement Medical Screening ___ Pre-placement Drug Testing ___ Drug-free Workplace ___ Pre-employment Reference Check ___ Union Employees ___	
Do you have an Injury and Illness Prevention Program? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a written early return-to-work program for employees injured on the job? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you document: Employee Training ___ Facility Inspections ___	
Describe your housekeeping: Good ___ Fair ___ Poor ___	Describe the condition of your equipment: Good ___ Fair ___ Poor ___
Have you received any OSHA citations within the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")	
Does the business provide temporary employees? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")	

Section 10 – Remarks (Attach a separate sheet if necessary.)

Section 11 – Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030			
BROKER ACCESS NUMBER	FIRM NAME		
ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		

SIGNATURE

To be completed by the broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge

Name: _____ Please print Title: _____ Please print

Signature: _____ Date: _____
(FAXed applications must be followed up with original document/signature.)