



Travelers Workers' Compensation
Supplemental Application

(Attach prior 4 years loss runs please.)

Named Insured _____ Effective Date _____

Mailing Address _____

Location Address _____

Location Address _____

Years in Business _____ Legal Entity _____

FEIN _____ State ID _____ NCCI ID _____

Experience Modification Factor _____

Limits Each Accident/Disease – Policy Limit / Disease – Each Employee				
Location #	Class Code /Category	Number of Full Time Employees	Number of Part Time Employees	Estimated Annual Remuneration

Officer / Partner Exclusions

Officer/Partner Name and Title _____

Officer/Partner Name and Title _____

Officer/Partner Name and Title _____

Officer/Partner Name and Title _____

Carrier / Premium / Loss Info							
Year	Co	Annual Premium	Mod	# Claims	Amt Paid	Reserve	Policy #

Inspection / Claim Kit Contact Person's Name

Name _____

Phone _____ Email Address _____

SIGNATURE _____ **DATE** _____



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FEIN _____

1. Total Number of Employees: _____ Full Time: _____ Part Time: _____ Temporary: _____
2. Is it a union shop? Yes No
3. Number of employees is or has been Increasing Decreasing Stable
4. Is group medical provided? Yes No Number of Employees participating _____
5. Employer designated clinic for industrial injury? Yes No
6. Are there pre-employment physicals? Yes No
7. Are employment references checked? Yes No
8. Is pre-employment drug screening performed? Yes No
9. Return to light duty plan? Yes No With full pay? Yes No
10. Is there a return to full time modified work plan? Yes No
11. Is there a formal safety program per SB198? Yes No
12. What does it consist of? _____

13. Is there a safety coordinator? Yes No Name of individual _____
14. Are safety meetings conducted? Yes No How often ? _____
15. Is there any unique safety measures in place? If so please specify _____

16. Is there an incentive program in place? Yes No
17. What types of job training are in place? _____

18. Is the insured maintaining their facilities and equipment? Yes No
19. How often? _____
20. How does the insured address housekeeping, industrial hygiene & ergonomics issues?

21. Are all machines equipped with safety guards? Yes No
22. Is there an aircraft or watercraft exposure? Yes No
23. Is there any athletic sponsorship? Yes No
24. Do employees drive their vehicles on the job? Yes No
25. Does the insured run MVR's? Yes No

SIGNATURE _____ **DATE** _____