



Travelers Workers' Compensation Supplemental Application

(Attach to ACORD application and prior 4 years loss runs please)

Named Insured _____ Effective Date _____

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 measure 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