

FARM LABOR SUPPLEMENTAL APPLICATION

Insured: _____ Eff Date: _____ FEIN NO. _____
 Contact Name & Title: _____ Tel. No.: _____ Fax No.: _____

INSURED HISTORY:

Years in business: _____ No. of locations _____ Description of operations _____

Out of state exposure: Yes No If YES, name of states: _____

Foreign Travel: Yes No

Present number of employees: Full-time employees _____ Part-time _____ Seasonal _____ Volunteers _____

Percent of employee turnover in the last 12 months Full-time _____ Part-time _____

Employee staffing expectation over the next 12 months Full-time \$ _____ Part-time _____

Benefits provided – are ALL employees eligible Yes No If NO, who is eligible _____

paid by employer % of participation

Group Health Yes No _____

Paid sick leave Yes No _____

Vacation Yes No _____

Retirement / Pension Plan Yes No _____

Name of Healthcare provider: _____

Provide name of clinic, physician, or emergency room used for work place related injury: _____

Full-time nurse maintained on staff: Yes No

CPR training provided Yes No

Would you be willing to participate in an HCO program to control claim costs? Yes No

Indicate the safety activities currently established and practiced regularly:

Safety program / IIPP in use compliant with SB 198 Yes No

Return to light duty plan Yes No Includes full wages Yes No

Return to Full-time modified work plan Yes No

Designated Full-time safety director Yes No Name: _____

Safety meetings held for all employees Yes No Frequency of meetings _____

Safety training held for all employees Yes No Incentive program for employees Yes No

Formal Employee Training

New Employee Training Yes No Employee App Yes No

Employees with new assignments Yes No Pre/Post Employment Physical Yes No

Piecework based compensation Yes No

Loss Control Incentive Program Yes No

All Machinery Properly Guarded Yes No

Lock Out / Tag Out Procedures Yes No

Mechanical Lifting Devices Yes No Maximum Manual Lifting _____ Pounds

Forklift Operators Cert Annually Yes No

Personal protective safety equipment provided for all employees Yes No

Supervisors are held accountable for injuries / accidents Yes No

Accident investigation program in place Yes No

OPERATIONS:

Operation includes delivery Yes No No. of authorized drivers _____ No. of vehicles _____

Frequency of delivery Daily Weekly Other _____

Delivery radius: < 50 miles 51-100 miles 101-250 miles >250 miles

Frequency of MVR checks _____ Participation in CHP Pull program Yes No

Driver acceptability standards have been established Yes No

Vehicles inspection / maintenance program Yes No Frequency _____

PAYROLL AND PREMIUM HISTORY:

Payroll Current Yr. _____
 1st Prior Yr. _____
 2nd Prior Yr. _____
 3rd Prior Yr. _____
 4th Prior Yr. _____

Premium: Current Yr. _____
 1st Prior Yr. _____
 2nd Prior Yr. _____
 3rd Prior Yr. _____
 4th Prior Yr. _____

FARMS:

Crops Grown	Avg. Acreage	Harvested Mechanically	Type of Equipment
		YES / NO	
		YES / NO	
		YES / NO	
		YES / NO	

1: How many acres: 160 or less 161-499 500-999 1,000+

2: Housing Provided: Yes No If so, how many employees _____

Building info: age _____ # stories _____ distance from medical clinic _____

3: Transportation of employees: Yes No

If YES, how?: Van Bus Airplane Other

Frequency: Daily Weekly Monthly Radius _____

Max number of employees in each vehicle: _____

4: Does insured harvest crops for others: Yes No

If YES, own equipment used Yes No

5: Crop dusting operations Yes No

If NO – certificate of insurance required Yes No

6: Herbicide/Pesticide application Yes No

If YES, safety program in place Yes No

Respiratory program in place Yes No

7: Shade/Water program in field Yes No

Details _____

8: Details on medical treatment program in field: How far is medical clinic?

9: Slip and fall (ladder/scaffolding-harness) program in place Yes No

Provide details:

10: Maximum height exposure: (How high off the ground is the max height an employee would be working?)

11: Company Vehicle (Type/Number of/Radius – if delivery or transportation of employees).

EXPOSURE INFORMATION-PREMISE-FIX LOCATION EMPLOYEE'S

Total number of employee's : _____ (COMPLETE THIS SECTION IF MORE THAN 50 EMPLOYEES)

State	Loc #	Payroll	Total # of Employees	# of shifts	Max # of ee's per shift	Bldg type (see below)	Year Built	# of Stories	Floors occupied
		\$							

If additional locations exist please included on a separate form.

Type of Building: (1.) Steel 3 stories or greater (2.) Frame 3 stories or less (3.) Concrete tilt up