

Cheval Insurance Services Workers Compensation Application

Business Legal Name

Mailing Address

City, State, Zip

Office Phone

Email Address

Is Applicant Street Address same as Mailing Address?

Yes

No

Location address below will be for actual location(s) at which work is done

Tax ID

Type of Tax ID

FEIN

SSN

SEIN

Do you have an Experience Modification Factor?

Yes

No

If Yes, WCIRB#

XMod%

Inception Date for Coverage

Is this a change from your normal anniversary date?

Yes

No

Business DBA - List all DBA's used. If DBA same as Legal Name, put SAME

Coverage includes Employers Liability with \$1,000,000 limit

Additional coverages

If you marked any additional coverages, provide details here:

Other States Coverage

Volunteer Coverage

Blanket Waiver of Subrogation

Specific Waiver of Subrogation

Legal Entity

Sole Proprietorship

Husband & Wife

Corporation

Limited Liability Company

Other:

Year Business Started

Location Information

Location 1 Address, City, State, Zip

List all class codes and employee payroll information for this location below, one line per code

Class Codes	# FT Employees	# PT Employees	Payroll
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Location 2 Address, City, State, Zip

List all class codes and employee payroll information for this location below, one line per code

Class Codes	# FT Employees	# PT Employees	Payroll
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Location 3 Address, City, State, Zip

List all class codes and employee payroll information for this location below, one line per code

Class Codes	# FT Employees	# PT Employees	Payroll
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Please list ALL individuals with controlling interest who are to be included or excluded on policy. This is usually all persons with an ownership interest.

Names and title/positions - list all clearly. add an extra sheet if needed.

Ownership %

Please indicate for each person listed above if they will be included for coverage or excluded. If excluded, do NOT include their compensation in Gross Payrolls

Include
Exclude

Has the business or any principal of the business declared bankruptcy in the last seven years?

Yes

No

Please provide contact information for policy and operations. If same as primary, list SAME

Primary Contact - name, email, phone

Inspection Contact - name, email, phone

Accounting Contact - name, email, phone

Claims Contact - name, email, phone

Loss Information - provide information on losses within the last 5 years.

Hard Copy Loss Runs Attached

No Previous Insurance

Licenses

CSLB #

CSLB License Type

Farm Labor Contractor #

ICC #

PUC #

DMV #

Other License Information:

Description of Operations: Please list all activities and operations of your business on all premises

Do any employees ride horses as part of their employment duties?

Yes

No

Do you provide housing or lodging for any employees? If yes, a supplement will be required.

Yes

No

General Questions

1. Any work performed on barges, vessels, docks, or bridges over water? Yes No

2. Do you obtain workers from a professional employer organization (PEO), employee leasing firm, labor contractor, or any third-party entity? Yes No

3. Do you obtain temporary workers from other employers? Yes No

Additional Questions

1. Do you use any equipment that bends, forms, shapes or cuts materials (eg. power press)? Yes No

2. Employ any relatives? Yes No

3. Employ any minors (under age 18)? Yes No

4. Make any cash payments to employees or subcontractors? Yes No

5. Provide Meal or lodging in lieu of wages? Yes No

6. Pay any employee by the piece? Yes No

7. Have any work at a maritime or offshore facility? Yes No

8. Have any locations/operations for which coverage is not required? Yes No

If Yes, provide location address and description of operations there.

9. Have any operations outside of California? Yes No

10. Perform any asbestos removal? Yes No

11. Member of any trade or business associations? Yes No

Please list memberships

Management Practices Questions

1. Do you offer an employee assistance program? Yes No

2. Do you offer paid vacations? Yes No

3. Do you offer paid sick leave? Yes No

4. Do you have an illness and injury prevention program? Yes No

5. Do you have a written return to work program for employees injured on the job? Yes No

6. Do you document employee training? Yes No

7. Do you document facility inspections? Yes No

8. Have you received any OSHA citations within the past year? Yes No

9. Do you provide temporary workers to other employers? Yes No

10. Check off the hiring practices implemented by your company:

Job Descriptions

Pre-placement medical screening

Pre-placement drug screening

Drug free workplace

Pre-employment reference checks

Union employees

Purchase/Acquisition Questions

Was this operation all or part of an existing business that was purchased or acquired?

Yes

No If no, skip to next section

What percentage of the business was acquired?

Date of ownership change

Prior business owner's name and address including business name(s)

Is/are the prior owner(s) related to the new owner(s)?

Yes

No

If Yes, explain relationship:

Have the operations changes since the business was acquired (eg from a bakery to a restaurant)?

Yes

No

If Yes, please explain:

Were more than 50% of the current employees hired since the acquisition?

Yes

No

If Yes, are those employees earning more than 50% of the payroll?

Yes

No

Have you ever been insured by State Fund before?

Yes

No

If yes, please provide last dates covered and applicable policy number

This information is correct to the best of my knowledge as of this date.

Form completed by (name, title)

Date of Completion

Signature