SUPPLEMENTAL APPLICATION

CharityFirst

Insured: Effective Date:
Contact Name & Title:
Tel. No.: ( ) - Fax No: ( ) - FEIN NO.:
Contact Email Address:

GENERAL INFORMATION:

Years in business: No. of locations: Hours of Operation: to
Description of operations:

Does the insured operate a retail, resale or thrift store? Yes ☐ No ☐
Does the retail, resale or thrift store accept electronics, appliances and furniture? Yes ☐ No ☐
Do they offer pick up service for the items above? Yes ☐ No ☐
Does the agency operate a sheltered workshop? Yes ☐ No ☐
Number of clients? Please describe operations of sheltered workshop?

Present number of employees: Full-time 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
Average hourly wage: Full-time $ Part-time $
Benefits provided – are ALL employees eligible Yes ☐ No ☐
If not then 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/MPN program to control claim costs? ☐ Yes ☐ No
Safety activities currently established and practiced regularly? ☐ Yes ☐ No
Written safety program compliant with state labor codes? ☐ 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
Personal protective safety equipment provided for all employees where necessary: ☐ Yes ☐ No
Supervisors are held accountable for injuries / accidents: ☐ Yes ☐ No
Accident investigation program in place: ☐ Yes ☐ No

Hiring Practices:

Employment application	☐ Yes	☐ No	Drug/substance abuse	☐ Yes	☐ No
Reference checks	☐ Yes	☐ No	Audiometric testing	☐ Yes	☐ No
Pre/Post employment physical	☐ Yes	☐ No	Orthopedic back test	☐ Yes	☐ No

VEHICLE USE:

Operations include vehicle exposure: ☐ Yes ☐ No # of authorized drivers: No. of vehicles:
Frequency of driving: ☐ Daily ☐ Weekly ☐ Other:
Driving radius: ☐ < 50 miles ☐ 51-100 miles ☐ 101-250 miles ☐ >250 miles
Frequency of MVR checks: Participation in an MVR Pull program: ☐ Yes ☐ No
Driver acceptability standards have been established: ☐ Yes ☐ No
Vehicles inspection / maintenance program: ☐ Yes ☐ No Frequency:
Any BIT inspections with unsatisfactory rating? ☐ Yes ☐ No
Vehicle maintenance is performed by employees: ☐ Yes ☐ No If no, then who?
Employees take vehicles home at night: ☐ Yes ☐ No
How many vehicles have a passenger capacity of 15 passengers or more vehicle?
Do company vehicles transport any non-employee passengers? ☐ Yes ☐ No Clients Only? ☐ Yes ☐ No
How many employees are allowed to ride at one time in the 15 passenger or more vehicles?
Do you have a driver safety program? ☐ Yes ☐ No If yes, please provide a copy for us

For the vehicles with passenger capacity > 15 passengers or over 10,000 GVW, please complete the following:

Vehicle Make & Model	Vehicle Year	Garage Location	Vehicle Radius	Annual Mileage Driven	Gross Vehicle Weight	Retail Deliveries Yes/No
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N

Please provide a list of driver's of the 15 passenger or more vehicles, please include their names, driver's license # and MVR'S (or attach a copy)?

Name	Driver's License No.	Motor Vehicle Record

PAYROLL AND PREMIUM HISTORY:

Payroll		Premium	
Current Year:	$	Current Year:	$
1st Prior Year:	$	1st Prior Year:	$
2nd Prior Year:	$	2nd Prior Year:	$
3rd Prior Year:	$	3rd Prior Year:	$
4th Prior Year:	$	4th Prior Year:	$

Does the Business use volunteers/donated labor? ☐ Yes ☐ No
Number of Volunteers? Average number of Hours?
Please describe their roles/responsibilities for the organization.