



Manchester Specialty Medical Staffing Supplemental Application

Insured Name:	Eff Date:
Insured Contact:	Date Business Established:
Insured Website:	ASA Member: <input type="checkbox"/> Yes <input type="checkbox"/> No

Prior Coverage Information:

	Current Year	Prior Year 1	Prior Year 2	Prior Year 3	Prior Year 4
Premium					
Payroll					
Carrier					

General Applicant Information:

		Details (if yes, details must be provided)
Expected % of growth this year	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any other commonly owned businesses that are separately insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any states in which you operate in that are covered elsewhere?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you provide group transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any outstanding WC premium or audit issues in the past 3 policy terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any foreign travel exposure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Operations Overview: (Must equal 100%)

% Temporary Placements	% Temp to Perm
% Contract Placements – Average length of contract?	% Direct Hire
% Day Labor	% PEO/Employee Leasing
% Payrolling – Explain:	

Locations where services are provided: (Must equal 100%)

% Private Home	% Assisted Living Facility
% Hospice	% Doctor’s Office
% Physical Rehab Facility	% Nursing Home
% Hospital	% Correctional Facility
% Psychiatric/Behavioral Health Facility	% Alcohol/Substance Abuse Facility
% Other Facility (please specify):	

Type of Placements: (Must equal 100%)

% Registered Nurse	% Licensed Practical Nurse/Vocational Nurse
% Certified Nurse Aid/Home Health Aid	% Sitters/Companions (non-medical)
% Homemaker (non-medical)	% Nurse Practitioner
% Physician Assistant	% Social Worker/Counselor
% Psychologist	% Respiratory Therapist
% Technicians (Radiology, Phlebotomy, etc)	% Speech/Occupational Therapist
% Physical Rehabilitation Therapist	% Clerical/Administrative
% Other (please specify):	



Client Information:

# of Active Clients:	Average # of New Clients Annually:
# of W2s (last calendar year):	# of 1099's (last calendar year):
# of Full-time Office Staff:	If 1099's, is payroll included for the workers' comp or are they required to carry their own coverage? <input type="checkbox"/> Included <input type="checkbox"/> Carry Own
Do you offer 24-hour care or do you provide live-in care? 24-hour care? Live-In care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, % of total services: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, % of total services:
Are there shifts over 10 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

Top 5 Clients:

Client Name	Description of Operations/Work Performed by temps	Class Code	State	Payroll	Client # of EEs	# of Temp EEs

Client Screening:

		Details (if yes, details must be provided)
Are there established Client Selection Criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a Job Hazard Analysis completed on all new clients? (provide sample copy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there procedures for terminating poor performing clients?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you review client's new worker orientation procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you review client's response procedures for emergency or accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you inspect worksites for safety PRIOR to employee placement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you or the client provide employees with written job descriptions/assignments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you or the client provide safety training? (please indicate which)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Safety Management:

Does your Safety Program include the following?		Details (if yes, details must be provided)
Full-time Safety Director (provide name, title & duties)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Written Safety Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Labor/Management Safety Committee	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Formal Written Accident Investigation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Proper lifting techniques instructions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Handling/Transfer Training	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bloodborne Pathogen/Infection Training & Procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Combative Patient Training & Procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Light Duty or Return to Work Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Claims Management:

Does your Claims Management program include:		Details (if yes, details must be provided)
Full time claims manager (provide name & title)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Claim fraud investigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Post-accident drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Established injury reporting procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Require all WC claims be reported within 24 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Process to identify claim frequencies & claim trends by client?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does Time Card have disclaimer about injury? (provide copy)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Screening:

Does your new hire Program Include the following?		Details (if yes, details must be provided)
Formal written job application	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Criminal Background Checks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reference Checks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Motor Vehicle checks on drivers	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Job experience & certification requirements	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pre-employment physicals	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug Testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Probationary Period	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Minimum experience requirements	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Any additional information?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Benefits:

Does your Employee Benefits Program for the temporary workers Include the following?	Waiting Period for Eligibility	% of EE Participation	Details (if yes, details must be provided)
Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Long-Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Short-Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid Vacation Days	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid Holidays	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid Sick Days	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Notice: This application is for the purposes of obtaining a quotation and does not bind the applicant or the Company to provide the insurance. The undersigned declares that to the best of his/her knowledge, the statements set forth herein are true. If the information suppliant herein changes between the date completed and the effective date of the insurance, the undersigned shall notify the Company of any changes and the Company reserves the right to modify or withdraw any offer of insurance.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or, conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject such person to criminal and civil penalties.

Signature Insured
Print Name/Title:

Signature Broker
Print Name/Title: