

SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

Section 1 - Trade Name (i.e., DBA)

Current:

Prior (if applicable):

Section 2 - Business Ownership

Legal Name:

Legal Entity (check one):

<input type="checkbox"/>	1	Individual (If married, check Husband & Wife)	<input type="checkbox"/>	N	Non-Profit Organization	<input type="checkbox"/>	C	Conservatorship
<input type="checkbox"/>	2	Husband & Wife (Both names required in Legal Name.)	<input type="checkbox"/>	3	Joint Venture	<input type="checkbox"/>	E	Estate
<input type="checkbox"/>	4	General Partnership	<input type="checkbox"/>	8	Public Agency	<input type="checkbox"/>	T	Trust
<input type="checkbox"/>	L	Limited Partnership	<input type="checkbox"/>	P	Incorporated Public Agency	<input type="checkbox"/>	6	Association
<input type="checkbox"/>	5	Corporation	<input type="checkbox"/>	9	Labor Union	<input type="checkbox"/>	J	Joint Employer
<input type="checkbox"/>	M	Non-Profit Corporation	<input type="checkbox"/>	U	Incorporated Labor Union	<input type="checkbox"/>	A	Common Ownership
						<input type="checkbox"/>	7	Other:

Section 3 - Licenses

2101 Farm Labor Contractor License:

3405 Contractor's State License Board No./Type/Expiration Date:

3408 PUC/ICC License Number:

3409 Other License Numbers required to do business in CA (please specify):

Section 4 - Additional Business Information

2075

Phones: Bus. () - Home () -

2075

FAX Number: () -

2075

E-Mail Address:

2099

State Employer Identification Number:

Section 5 - Social Security Number(s)

2096

Please provide the Social Security Number(s)* for individual owner, husband, wife, corporate officers, or general partners. Attach a separate page if necessary.

- | | |
|-----------------|------------------------------|
| (1) Name: _____ | *Social Security Number: - - |
| (2) Name: _____ | *Social Security Number: - - |
| (3) Name: _____ | *Social Security Number: - - |
| (4) Name: _____ | *Social Security Number: - - |

***DISCLOSURE STATEMENT**

Providing Social Security Numbers is voluntary. If the principals do not wish to provide Social Security Numbers, other acceptable identification shall include: 1) Federal Employer Identification Number (FEIN), 2) State Employer Identification Number (SEIN), 3) Contractor's License or 4) any applicable business license pertinent to the trade or business.

Section 6 - General Information

Do any of the following pertain to the operations of this risk? Please explain all "yes" answers to questions 1-10 in the "Remarks" section on page 2.

	Yes	No		Yes	No
1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press)?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have any location/operations for which coverage is not requested?	<input type="checkbox"/>	<input type="checkbox"/>
2. Employ any relatives?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have any operations outside of California?	<input type="checkbox"/>	<input type="checkbox"/>
3. Employ any minors (under age 18)?	<input type="checkbox"/>	<input type="checkbox"/>	10. Perform any asbestos removal?	<input type="checkbox"/>	<input type="checkbox"/>
4. Make any cash payments to employees or subcontractors?	<input type="checkbox"/>	<input type="checkbox"/>	11. Member of any trade or business association?	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide meals or lodging in lieu of wages?	<input type="checkbox"/>	<input type="checkbox"/>	Please indicate: _____		
6. Pay any employees by the piece?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
7. Have any work at a maritime or offshore facility?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Section 7 - Has the business or any principal of the business declared bankruptcy in the last seven years? Yes No, skip to Section 8

Name of Principal:

3105 Chapter of bankruptcy filed (check as applicable): 7 11 13 Other:

Date filed: _____ Case Number: _____ Status: pending dismissed discharged

Court where case was filed (Please provide us with a filed, stamped copy of the "Petition for Relief".):

Section 8 - Was this operation all or part of an existing business that was purchased or acquired? Yes No, skip to Section 9

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What percentage of the business was acquired?: _____	Date ownership changed: _____
Prior business owner's name and address:	
Name: _____	
Address: _____	
Name of Business: _____	
Is the prior owner(s) related to the new owner(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Relationship: _____	
Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____	
Were more than 50% of the current employees hired since the acquisition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are those new employees earning more than 50% of the payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 9 - Management Practices

Please indicate if you offer: Employee Assistance Program <input type="checkbox"/> Paid Vacations <input type="checkbox"/> Paid Sick Leave <input type="checkbox"/>
Do you have a minimum of 2 employees? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, do you pay at least 50% of the Health Insurance premium? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Health Insurance Carrier: _____
Please check off the hiring practices implemented by your company: Job Descriptions <input type="checkbox"/> Pre-placement Medical Screening <input type="checkbox"/>
Pre-placement Drug Testing <input type="checkbox"/> Drug-free Workplace <input type="checkbox"/> Pre-employment Reference Check <input type="checkbox"/> Union Employees <input type="checkbox"/>
Do you have an injury and illness Prevention Program? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a written early return-to-work program for employees injured on the job? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you document: Employee Training <input type="checkbox"/> Facility Inspections <input type="checkbox"/>
Describe your housekeeping: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Describe the condition of your equipment: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
Have you received any OSHA citations within the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")
Does the business provide temporary employees? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")

Section 10 - Remarks (Attach a separate sheet if necessary.)

Section 11 - Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030			
BROKER ACCESS NUMBER	FIRM NAME		
ADDRESS	CITY	STATE	ZIP
() -	() -		
PHONE NUMBER	FAX NUMBER		

SIGNATURE

To be completed by broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Name: _____ Please print	Title: _____ Please print
Signature: _____ (FAXed applications must be followed up with original document/signature.)	Date: _____