

**HEALTHCARE SUPPLEMENTARY  
WORKERS COMPENSATION APPLICATION**

LEMIC Insurance Company  
c/o CCMSI

Post Office Box 6967  
Metairie, Louisiana 70009

PHONE: (866) 314-9970

FAX: (866) 883-8413

**NAME OF APPLICANT:** \_\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**CITY / STATE / ZIP:** \_\_\_\_\_

**GENERAL EXPOSURE INFORMATION**

Description of Operations:

\_\_\_\_\_

Number of years in business under the above name / operation:

\_\_\_\_\_

Prior Workers Compensation Coverage:

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

Name of Current Carrier

\_\_\_\_\_

a. If none, provide the owner(s) experience in managing or operating this type of business:

\_\_\_\_\_

Does the applicant own (or is affiliated with) any business other than this submission?

\_\_\_\_\_ Yes                      \_\_\_\_\_ No (if yes, please explain)

\_\_\_\_\_

What percentage of work is performed in the following categories? (must equal 100%)

|                        |       |                                |       |
|------------------------|-------|--------------------------------|-------|
| Assisted Living Center | _____ | Hospital Services (inpatient)  | _____ |
| Home Health Care       | _____ | Hospital Services (outpatient) | _____ |
| Home Infusion          | _____ | Pharmacy Services              | _____ |
| Homemaker Services     | _____ | Physical Therapy               | _____ |
| Hospice                | _____ | Staffing Services (temp/perm)  | _____ |
| Other (describe)       | _____ |                                |       |

\_\_\_\_\_

Based on the above work exposures, what is the break down of employees under Direct Payroll (W-2 filed) and / or Subcontracted (1099 or other) according to the following jobs performed? (include full / part time totals)

|                    | Number Employed | Number Contracted | Hospital Percent | Nursing Home | Client's Home |
|--------------------|-----------------|-------------------|------------------|--------------|---------------|
| Aides              |                 |                   |                  |              |               |
| LPN's              |                 |                   |                  |              |               |
| RN's               |                 |                   |                  |              |               |
| Nurse Practitioner |                 |                   |                  |              |               |
| Other (specify)    |                 |                   |                  |              |               |

Does the insured utilize contracted / subcontracted staffing for any services?

\_\_\_\_\_ Yes \_\_\_\_\_ No (if yes, answer sections below)

a. Percentage of annual exposure (based on cost of labor / material) \_\_\_\_\_

b. Type of work contracted on normal basis \_\_\_\_\_

c. Are Certificates of Insurance maintained for the Workers Comp coverage?

\_\_\_\_\_ Yes \_\_\_\_\_ No

(if no, exposure not indicated will be picked up at audit by Carrier)

Does applicant have a formal safety program incorporated in operations?

\_\_\_\_\_ Yes \_\_\_\_\_ No

a. Does program include the incorporation of the following?

|   |     |    |
|---|-----|----|
| Periodical Safety Meeting(s), documented? | YES | NO |
| Written Safety Inspection Program?        | YES | NO |
| Formal Lift Protection Plan?              | YES | NO |
| Formal Fall Protection Plan?              | YES | NO |
| Pre Hire Drug Testing?                    | YES | NO |
| Post Accident Drug Testing?               | YES | NO |
| Second Injury Questionnaire Completed?    | YES | NO |

b. If No to above, is applicant willing to implement safeguards into program?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Are all visits to patients' homes documented by employees accurately with report logs?  
If Yes, how often are reports submitted to management?

What specific types of training do employees receive? \_\_\_\_\_

Is updated training provided on a regular basis? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please advise how often. \_\_\_\_\_

What types of vehicles are used in the insured's operation? \_\_\_\_\_  
What is the radius of operation? \_\_\_\_\_  
Are travel logs maintained? \_\_\_\_\_

Are MVRs reviewed on a regular basis? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, what are the maximum allowable violations for moving and/or major incidents?  
\_\_\_\_\_

Are background checks performed on prospective new professional hires?  
\_\_\_\_\_ Yes \_\_\_\_\_ No  
New non-professional hires?  
Yes \_\_\_\_\_ No

What is the maximum allowable ratio between ambulatory / non-ambulatory patients?  
\_\_\_\_\_

Please advise of any specific accreditation(s) held by the company and / or professional employees.  
\_\_\_\_\_  
\_\_\_\_\_

The purpose of the Healthcare Supplemental Application is to assist in the underwriting process. Information contained herein is specifically relied upon in the determination of insurability. The undersigned, therefore warrants that the information contained herein (consisting of two pages) is true and accurate to the best of his knowledge, information and belief. The supplemental application and the application to which it is appended, shall be the basis of any insurance policy that may be issued and will become part of such policy. A signature is required on completed form at the time of binding and will be subject to verification as determined by the Loss Control Survey required by Carrier. Any information not provided and/or proved to vary from the above will be subject to review for possible cancellation.

Signature of Applicant\*

\_\_\_\_\_  
\* must be completed by an owner, officer or authorized representative

Name & Title of Above \_\_\_\_\_

Date \_\_\_\_\_