Healthcare Workers' Compensation Self-Insurance Fund HWCF

PARTICIPANT APPLICATION FOR WORKERS' COMPENSATION COVERAGE

P. O. Box 211359
Montgomery, AL 36121-1359

Important: All questions must be answered completely. Please indicate if a question does not apply by using N/A. If more space is required to answer a question, please use a separate page.

Legal Name: _____

D/B/A: _____

Mailing Address: _____

☐ If name has changed, previous name: _____

☐ Individual ☐ Corporation ☐ Partnership ☐ LLC ☐ Other – Specify _____

EXECUTIVE CONTACT	FACILITY CONTACT	BILLING CONTACT
Name:	Name:	Name:
Title:	Title:	Title:
Email:	Email:	Email:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:

PARTICIPANT INFORMATION

Effective Date:	Number of Years in Business:
Federal Employer Identification #:	Website Address:
Unemployment Compensation #:	Social Media Website Address:

DESIRED PAYMENT PLAN ☐ Annual ☐ Quarterly ☐ Bi-monthly

TYPE OF FACILITY

☐ Hospital – Specify Type: _____
☐ Surgical Center
☐ Nursing Home
☐ Retirement/Assisted Living Center
☐ Clinic – Specify Type: _____
☐ Laboratory
☐ Home Health
☐ Hospice
☐ Dentist's Office
☐ Physician's Office
☐ Mental Health Facility
☐ Other: _____

RATING INFORMATION SECTION – STATE: ALABAMA ONLY

Estimated amount of payroll and number of employees for next twelve (12) months beginning on effective date of coverage. List payrolls for each classification. In the additional space, list information for classifications which are not specifically listed.

Class Code Number	Description of Classifications	Estimated Gross Payroll	# Employees	
			Full Time	Part Time
7370	Ambulance (Non-Emergency & Non Certified Runs)			
7380	Drivers, Chauffeurs			
7705	Ambulance (Emergency & Certified Runs)			
7720	Security Guard			
8017	Store Retail - NOC			
8742	Salespersons / Outside			
8810	Clerical Office Employees			
8824	Retirement LC / Health Care			
8825	Retirement LC / Food Service			
8826	Retirement LC / All other employees			
8829	Nursing Home / Convalescent			
8832	Physician / Clerical – Dental / Clerical			
8833	Hospital: Professional Employees			
8835	Home Health Care			
8842	Mental Health / Group Homes			
8864	Social Services Organization			
8869	Child Care Center			
9015	Building – NOC			
9040	Hospital: All Other Employees			
9063	Health Exercise Facility			
	Other:			

INDIVIDUALS INCLUDED / EXCLUDED

Partners, Officers, LLC Members, or Sole Proprietors to be Included or Excluded (Remuneration/Payroll to be included ***must be*** part of the rating information section.)

Name	Title	Ownership%	Duties	Inc / Exc	Class Code	Remuneration/Payroll

EMPLOYER PHYSICAL LOCATIONS

Location #	D/B/A, Street, City, State, Zip	Total at Location	Total of Largest Shift

PERMANENT LOCATIONS IF DIFFERENT FROM EMPLOYER PHYSICAL LOCATIONS

Location #	D/B/A, Street, City, State, Zip	Total at Location	Total of Largest Shift

CARRIER HISTORY

Provide Information for the Past 5 Years of Business

Year	Carrier and Policy Number	Annual Contribution	Mod

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GENERAL INFORMATION

1. (a) At any time does your facility own, operate or lease aircraft? ☐ Yes ☐ No

   (b) At any time does your facility own, operate or lease an ambulance? ☐ Yes ☐ No

   If "yes", what employees are involved in the transport of patients? _____

   What employees are involved in the loading and unloading of patients? _____

2. Are there any exposures to flammables, explosives, caustics, fumes or radioactive materials? ☐ Yes ☐ No

   If "yes", please explain: _____

3. Does your facility use contract labor? ☐ Yes ☐ No

   If "yes", please explain: _____

   If "yes", do these workers have evidence of Workers' Compensation coverage? ☐ Yes ☐ No

4. Are athletic teams sponsored? ☐ Yes ☐ No

   If "yes", please explain: _____

5. Does your facility absorb/write off any of the cost for medical-only claims? ☐ Yes ☐ No

   What amount? _____

6. Has the facility had any significant lay-offs in the past three years? ☐ Yes ☐ No

   If "yes", for what reason? _____

   Approximate number of employees involved: _____

7. Is there an employee disability program in force at your facility? ☐ Yes ☐ No

   If "yes", please explain: _____

8. Do you provide job descriptions for each employee? ☐ Yes ☐ No

Do the job descriptions explain physical requirements necessary for each employee to do his job? ☐ Yes ☐ No

Are hazardous material exposures explained? ☐ Yes ☐ No

Are working conditions explained in the job description? ☐ Yes ☐ No

9. Is a written safety program in operation? ☐ Yes ☐ No

10. Are safety rules published and reviewed with each employee? ☐ Yes ☐ No

Are safety rules posted where employees can read them? ☐ Yes ☐ No

11. Are pre-placement physicals required? ☐ Yes ☐ No

If "yes", who gives these physicals? _____

If "no", do you plan to make pre-placement physicals a requirement in the next twelve months? ☐ Yes ☐ No

12. Is there a modified duty return to work program in place? ☐ Yes ☐ No

If "no", would you be willing to start such a program? ☐ Yes ☐ No

13. What type of training is given to employees in regard to body mechanics/lifting techniques? _____

_____

How often is that training provided to all employees? _____

14. Are there any employees under 16 or over 65 years of age? ☐ Yes ☐ No

If "yes", please explain their duties: _____

15. Are there any part-time employees? ☐ Yes ☐ No

If "yes", please explain their duties: _____

16. Are there any volunteers or donated labor? ☐ Yes ☐ No

If "yes", # of Volunteers: _____

17. Is any group transportation of employees provided? ☐ Yes ☐ No

What type of vehicle is used? _____

Do any employees use their own vehicles for facility business? ☐ Yes ☐ No

If "yes", for what purpose? _____

18. Do employees travel out-of-state on business (other than incidental)? ☐ Yes ☐ No

If "yes", what states do they travel or work in and why? _____

19. Do you employ union employees? ☐ Yes ☐ No

If "yes", to what extent? _____

20. Have any employees in the past five years been compensated because of occupation disease or illness contracted during their employment? ☐ Yes ☐ No

If "yes", give number of employees and the type of illness: _____

21. Do you have any offsite activities or sponsorships where employees volunteer? ☐ Yes ☐ No

If "yes", please explain: _____

22. Is your workplace Drug Free Certified through the Department of Labor? ☐ Yes ☐ No

If "yes", can you produce a current copy of the Drug Free Certified Workplace Certificate? ☐ Yes ☐ No

23. Any work performed underground or above 15 feet? ☐ Yes ☐ No

If "yes", please explain: _____

24. Any prior coverage declined/cancelled/non-renewed in the last (3) years? ☐ Yes ☐ No

If "yes", please explain: _____

25. Are employee health plans provided? ☐ Yes ☐ No

If "yes", please explain: _____

26. Do any employees perform work for other businesses or subsidiaries? ☐ Yes ☐ No

If "yes", please explain: _____

27. Do any employees predominantly work at home? ☐ Yes ☐ No

If "yes", # of Employees: _____

28. Is this entity a PEO, Temporary Staffing Agency, or Client Company of a PEO? ☐ Yes ☐ No

If "yes", please explain: _____

29. Any tax liens or bankruptcy within the last 5 years? ☐ Yes ☐ No

If "yes", please specify: _____

30. Are any employees solely dedicated to Risk Management? ☐ Yes ☐ No

If "yes", please provide a point of contact and phone number: _____

The undersigned authorized individual of the Organization declares that to the best of his/her knowledge, the statements set forth herein are true. Signing of this application does not bind the undersigned or the insurance company to complete this insurance, but it is agreed that this form shall be the basis of the contract should coverage be issued.
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for coverage is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

_____ _____

Date **Signature of Owner, Partner or Corporate Officer & Title**