STATE COMPENSATION INSURANCE FUND

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):

	1	Individual (If married, check Husband & Wife)		N	Non-Profit Organization		C	Conservatorship
	2	Husband & Wife (Both names required in Legal Name.)		3	Joint Venture		E	Estate
	4	General Partnership		8	Public Agency		T	Trust
	L	Limited Partnership		P	Incorporated Public Agency		6	Association
	5	Corporation		9	Labor Union		J	Joint Employer
	M	Non-Profit Corporation		U	Incorporated Labor Union		A	Common Ownership
							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)?			8. Have any locations/operations for which coverage is not requested?		
2. Employ any relatives?			9. Have any operations outside of California?		
3. Employ any minors (under age 18)?			10. Perform any asbestos removal?		
4. Make any cash payments to employees or subcontractors?			11. Member of any trade or business association? Please indicate: _____		
5. Provide meals or lodging in lieu of wages?					
6. Pay any employees by the piece?					
7. Have any work at a maritime or offshore facility?					

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**

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)? ☐ No ☐ Yes, Relationship:

Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? ☐ No ☐ Yes, please explain:

Were more than 50% of the current employees hired since the acquisition? ☐ Yes ☐ No	Are those new employees earning more than 50% of the payroll? ☐ Yes ☐ No

Section 9 – Management Practices

Please indicate if you offer: Employee Assistance Program ___ Paid Vacations ___ Paid Sick Leave ___

Do you have a minimum of 2 employees? ☐ No ☐ Yes

If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) ☐ No ☐ Yes

If yes, do you pay at least 50% of the Health Insurance premium? ☐ No ☐ Yes, Name of Health Insurance Carrier:

Please check off the hiring practices implemented by your company: Job Descriptions ___ Pre-placement Medical Screening ___ Pre-placement Drug Testing ___ Drug-free Workplace ___ Pre-employment Reference Check ___ Union Employees ___

Do you have an Injury and Illness Prevention Program? ☐ No ☐ Yes

Do you have a written early return-to-work program for employees injured on the job? ☐ No ☐ Yes

Do you document: Employee Training ___ Facility Inspections ___

Describe your housekeeping: Good ___ Fair ___ Poor ___ | Describe the condition of your equipment: Good ___ Fair ___ Poor ___

Have you received any OSHA citations within the past year? ☐ No ☐ Yes (Please explain in "Remarks.")

Does the business provide temporary employees? ☐ No ☐ 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 the 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: _____ Title: _____

Please print Please print

Signature: _____ Date: _____

(FAXed applications must be followed up with original document/signature.)