CharityFirst
Risk Solutions. Nonprofit Expertise.

SUPPLEMENTAL APPLICATION

Insured: Effective Date:

Contact Name & Title:

Tel. No.: ( ) - Fax No: ( ) - FEIN NO.:

Contact Email Address:

GENERAL INFORMATION:

Years in business: No. of locations: Hours of Operation: to
Description of operations:

Does the insured operate a retail, resale or thrift store? Yes ☐ No ☐
Does the retail, resale or thrift store accept electronics, appliances and furniture? Yes ☐ No ☐
Do they offer pick up service for the items above? Yes ☐ No ☐
Does the agency operate a sheltered workshop? Yes ☐ No ☐
Number of clients? Please describe operations of sheltered workshop?

Present number of employees: Full-time Part-time Seasonal Volunteers
Percent of employee turnover in the last 12 months: Full-time % Part-time %
Employee staffing expectation over the next 12 months: Full-time Part-time
Average hourly wage: Full-time $ Part-time $
Benefits provided – are ALL employees eligible ☐Yes ☐No
If not then who is eligible?

			% paid by employer	% of participation
Group Health	☐Yes	☐No	%	%
Paid sick leave	☐Yes	☐No	%	%
Vacation	☐Yes	☐No	%	%
Retirement / Pension Plan	☐Yes	☐No	%	%

Name of Healthcare provider:
Provide name of clinic, physician, or emergency room used for work place related injury:

Full-time nurse maintained on staff: ☐Yes ☐No
CPR training provided: ☐Yes ☐No
Would you be willing to participate in an HCO/MPN program to control claim costs? ☐Yes ☐No
Safety activities currently established and practiced regularly? ☐Yes ☐No
Written safety program compliant with state labor codes? ☐Yes ☐No
Return to light duty plan: ☐Yes ☐No Includes full wages? ☐Yes ☐No
Return to Full-time modified work plan: ☐Yes ☐No
Designated Full-time safety director: ☐Yes ☐No Name:
Safety meetings held for all employees: ☐Yes ☐No Frequency of meetings:
Safety training held for all employees: ☐Yes ☐No Incentive program for employees: ☐Yes ☐No
Personal protective safety equipment provided for all employees where necessary: ☐Yes ☐No
Supervisors are held accountable for injuries / accidents: ☐Yes ☐No
Accident investigation program in place: ☐Yes ☐No

Hiring Practices:

Employment application	☐Yes	☐No	Drug/substance abuse	☐Yes	☐No
Reference checks	☐Yes	☐No	Audiometric testing	☐Yes	☐No
Pre/Post employment physical	☐Yes	☐No	Orthopedic back test	☐Yes	☐No

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VEHICLE USE:

Operations include vehicle exposure: ☐Yes ☐No # of authorized drivers: No. of vehicles:
Frequency of driving: ☐Daily ☐Weekly ☐Other:
Driving radius: ☐< 50 miles ☐51-100 miles ☐101-250 miles ☐>250 miles
Frequency of MVR checks: Participation in an MVR Pull program: ☐Yes ☐No
Driver acceptability standards have been established: ☐Yes ☐No
Vehicles inspection / maintenance program: ☐Yes ☐No Frequency:
Any BIT inspections with unsatisfactory rating? ☐Yes ☐No
Vehicle maintenance is performed by employees: ☐Yes ☐ No If no, then who?
Employees take vehicles home at night: ☐Yes ☐No
How many vehicles have a passenger capacity of 15 passengers or more vehicle?
Do company vehicles transport any non-employee passengers? Yes ☐ No ☐ Clients Only? Yes☐ No☐
How many employees are allowed to ride at one time in the 15 passenger or more vehicles?
Do you have a driver safety program? Yes ☐ No☐ If yes, please provide a copy for us

For the vehicles with passenger capacity > 15 passengers or over 10,000 GVW, please complete the following:

Vehicle Make & Model	Vehicle Year	Garage Location	Vehicle Radius	Annual Mileage Driven	Gross Vehicle Weight	Retail Deliveries Yes/No
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N
						☐Y ☐N

Please provide a list of driver's of the 15 passenger or more vehicles, please include their names, driver's license # and MVR'S (or attach a copy)?

Name	Driver's License No.	Motor Vehicle Record

PAYROLL AND PREMIUM HISTORY:

Payroll		Premium	
Current Year:	$	Current Year:	$
1st Prior Year:	$	1st Prior Year:	$
2nd Prior Year:	$	2nd Prior Year:	$
3rd Prior Year:	$	3rd Prior Year:	$
4th Prior Year:	$	4th Prior Year:	$