Berkshire Hathaway
HOMESTATE COMPANIES

# Supplemental Application

Insured: Eff. Date:
Contact Name & Title: Tel. #.: Fax #.: Website Address :

## GENERAL INFORMATION:

Years in business: # of locations
Description of operations
Union: ☐Yes ☐No If yes, name of Union
Current 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 in Governing Class: Full time $ Part time $
Average hourly wage in Clerical class: Full time $ Part time
Average hourly wage in Sales class: Full time $ Part time
Has the insured ever been in bankruptcy? ☐ Yes ☐ No If yes, explain

______________ ______________________________________________

## BENEFITS:

Are ALL employees eligible Y/N; if no then who?
% 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:
Do you use a specific: Clinic Physician Emergency room
CPR training provided? ☐ Yes ☐ No

## SAFETY PROGRAM:

Safety program / IIPP compliant with SB 198 ☐ Yes ☐ No
Return to light duty plan ☐ 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 ☐ Yes ☐ No
Supervisors are held accountable for injuries / accidents ☐ Yes ☐ No
Accident investigation program in place ☐ Yes ☐ No
Do you have a Health & Wellness program? ☐ Yes ☐ No
Describe Health & Wellness activities: (eg. physical fitness and nutrition assessment and consultation, lifestyle health risk appraisal, discounted gym membership, walk-at-lunch program, weight loss/smoking cessation program, stress reduction, first aid, blood pressure management, physical demand validation of job descriptions, etc.)

## HIRING PRACTICES:

Employment application ☐ Yes ☐ No Drug/substance abuse ☐ Yes ☐ No
Reference checks ☐ Yes ☐ No Audiometric Testing ☐ Yes ☐ No
Motor Vehicle Record Check ☐ Yes ☐ No Pre/Post employment physical ☐ Yes ☐ No
Volunteer Labor used ☐ Yes ☐ No Pathogenic test (i.e. lead ) ☐ Yes ☐ No
Temporary labor used ☐ Yes ☐ No Orthopedic back test ☐ Yes ☐ No



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## OPERATIONS:

Hours of operation: to Number of daily shifts
Operation includes driving? ☐ Yes ☐ No Number of authorized drivers No. of vehicles
Types of vehicles driven
Reason(s) for driving (delivery, sales calls, etc.)?
Frequency of driving: Daily ☐ Weekly ☐ Other ☐
Driving radius: < 50 miles ☐ 51-100 miles ☐ 101-250 miles ☐ 250 miles ☐
Frequency of MVR checks Participation in CHP Pull program ☐ Yes ☐ No
Driver acceptability standards have been established ☐ Yes ☐ No
Vehicles inspection / maintenance program ☐ Yes ☐ No Frequency
Vehicle maintenance performed is performed by employees ☐ Yes ☐ No
Employees take vehicles home ☐ Yes ☐ No
Motor Carrier Permit (MCP) Filing Number:

## PAYROLL AND PREMIUM HISTORY:

| Payroll: | | Premium: |
|---|---|---|
| | Current year: | Premium: Current year: |
| | 1st Prior Year: | Premium: 1st Prior Year: |
| | 2nd Prior Year: | Premium: 2nd Prior Year: |
| | 3rd Prior Year: | Premium: 3rd Prior Year: |
| | 4th Prior Year: | Premium: 4th Prior Year: |

Any travel out of Country/ State? ☐ Yes ☐ No No. of employees who travel: Frequency
What Countries and/or States?
Purpose:

## HOTEL / MOTEL:

Number of guest rooms: _______ Room rate: Under $50 ☐ $50-74.95 ☐ $75-99 ☐ Over $100 ☐
Food service: Operate own: ☐ Yes ☐ No Subcontract: Restaurant ☐ Bar ☐ Both ☐
Gross receipts: Food % Liquor %
Entertainment: ☐ Yes ☐ No Lounge: ☐ Yes ☐ No Armed Security: ☐ Yes ☐ No
Operation: Year round ☐ Seasonal ☐ Conference center: ☐ Yes ☐ No
Shuttle service: ☐ Yes ☐ No How many vans:
How are maids compensated: Salary ☐ Hourly wage ☐ Flat rate per room ☐
Who flips the mattresses and how are they turned:

## RETAIL / WHOLESALE:

Gross receipts: Wholesale % Retail %
Type of merchandise
Palletized: ☐ Yes ☐ No
Lifting exposure or repackaging: ☐ Yes ☐ No Lbs:
Forklift exposures describe:

Compensation: Flat salary Hourly wage
Commission
Outside sales employees: ☐ Yes ☐ No
Is there assembly: ☐ Yes ☐ No If yes, what?

## MANUFACTURING & ASSEMBLING:

Machine guarding: Point of operation: ☐ Yes ☐ No
Drive mechanism: ☐ Yes ☐ No
Moving Parts: ☐ Yes ☐ No Lock out/tag out: ☐ Yes ☐ No
% of – Point of operation guarding:
Moving parts Drive Mechanism:
**TYPE OF MACHINES USED?**

Any piece-work or home-based work? ☐ Yes ☐ No
If yes, explain:

Material handling exposure: ☐ Yes ☐ No
Lifting: ☐ Below 50 lbs. ☐ Above 50 lbs.
Off premises operations: ☐ Yes ☐ No Percentage
Where / What:
Personal Protection Equipment provided? ☐ Yes ☐ No
Use enforced? ☐ Yes ☐ No



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## SERVICE STATIONS / AUTO REPAIR SHOPS / TRANSMISSION SHOPS:

Hours of Operation ______________________________
Gas operation: ☐ Full Service ☐ Self service
Repair operation: ☐ Yes ☐ No
☐ Tire repair/installation ☐ Over 1-ton truck (yes/no)
Towing: ☐ Yes ☐ No Contract tow: ☐ Yes ☐ No
Road Repair: ☐ Yes ☐ No

Mini-Market: ☐ Yes ☐ No Liquor sold? ☐ Yes ☐ No
Bullet proof cashier booth: ☐ Yes ☐ No
Drop safe or registers: ☐ Yes ☐ No
Car Wash: ☐ Yes ☐ No *If yes,* ☐ self serve ☐ full serve
Access to freeway: ☐ 0-1 mile ☐ 1-2 miles ☐ 2+ miles

## ATTORNEYS

What type of law:
Any criminal law: ☐ Yes ☐ No Percentage Any insurance law: ☐ Yes ☐ No Percentage

## RESTAURANT:

Average Entrée Price:
Liquor Receipts (% of gross receipts)
Entertainment: ☐ Yes ☐ No If yes, please provide details:

Catering: ☐ Yes ☐ No % of revenues:
Radius:

Delivery: ☐ Yes ☐ No % of revenues:
Radius:

Separate Lounge: ☐ Yes ☐ No
Twenty-four hour operation: ☐ Yes ☐ No
Multiple Floor levels ☐ Yes ☐ No
Number of: Hosts Valet Parkers
Waitpersons Bartenders

Cooks Take-out: ☐ Yes ☐ No

## APARTMENT OWNER OR OPERATOR:

List of operations sub-contracted to others: ______________________________________________

Current employees perform sub-contracted operations for you? ☐ Yes ☐ No *If yes*, please list:
The following items are maintained and kept current for all sub-contractors:
Certificate of workers' compensation insurance ☐ Yes ☐ No
Copy of each sub-contractor's license number ☐ Yes ☐ No

## JANITORIAL:

Percentage of revenues from: Office Buildings Manufacturing Plants Medical Properties Other

Pressure cleaning? ☐ Yes ☐ No Concrete cleaning or sealing ? ☐ Yes ☐ No Roof or gutter cleanup? ☐ Yes ☐ No
Window Washing requiring ladder or other device for heights ☐ Yes ☐ No Large Debris hauling ☐ Yes ☐ No
Other work requiring ladders ☐ Yes ☐ No Multiple Locations per night ☐ Yes ☐ No Group Transportation ☐ Yes ☐ No
Confined Space (vents, etc) ☐ Yes ☐ No Buffing waxing carpet cleaning ☐ Yes ☐ No

## FARMING OPERATIONS:

Row Crops: % Trees/Vines: % Dairy/Cattle: %
Is housing provided? ☐ Yes ☐ No If yes, how many employees?
How many acres: 160 or less ☐ 161-499 ☐ 500-999 ☐ 1000+ ☐
Transportation of employees: ☐Yes ☐No If yes, how: Van☐ Bus ☐ Other ☐; Frequency: Daily ☐Weekly ☐ Monthly ☐ Radius ☐
Use Labor Contractor? ☐ Yes ☐ No
How are employees paid? Hourly rate Piece rate Combination Other
Dairy Barn: Elevated☐ Carousel ☐ Flat ☐ Other
Number of milking cows
Number of bulls Number of bulls 3 years and older
Outside Veterinary Services ☐ Yes ☐ No

- Artificial Insemination: ☐ Yes ☐ No Subcontracted? ☐ Yes ☐ No
- Hoof trimming: ☐ Yes ☐ No Subcontracted? ☐ Yes ☐ No
- De-horning: ☐ Yes ☐ No Subcontracted? ☐ Yes ☐ No
- Does insured harvest for others? ☐ Yes ☐ No If yes, own equipment used? ☐ Yes ☐ No



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**CONSTRUCTION: (Includes Landscapers and Artisan Contractors)**

Contractor’s License # Copy Included ☐ Yes ☐ No Classification
Detailed Description of Operation

Estimated Gross Receipts Estimated Subcontractors Receipts
Sub-contractors Certificates sent to agent? ☐ Yes ☐ No
Residential % Commercial % Re-model % New Contract %
Types of machinery and hand tools used
Proper guarding & maintenance in place ☐ Yes ☐ No
Any work performed above 2 stories: ☐ Yes ☐ No
If yes , explain
Any Roof Exposure: ☐ Yes ☐ No If yes, explain:
Any Concrete Tilt-Up Work: ☐ Yes ☐ No
Any work performed underground? : ☐ Yes ☐ No Max depth:
If yes, explain:
Details of Interior and/or Exterior work performed:

Any use of Cranes: ☐ Yes ☐ No If yes, explain
Any use of Scaffolds: ☐ Yes ☐ No If yes, are the ee’s certified?
Safety training provided ☐ Yes ☐ No
Details

Level of Supervision
# of staff to Supervisors
Personal protective wear available? ☐ Yes ☐ No Examples:

Type of vehicles # of Vehicles Transportation of employees? ☐ Yes No☐

# of Drivers

Percentage of OCIP work anticipated in the upcoming year? %
Percentage of OCIP work performed in the past 2 years? %



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**Alcoholic and Drug Recovery Homes, Social Rehabilitation Facilities for Adults, Nursing Homes, Convalescent Homes or Convalescent Hospitals, Rest Homes, Sanitariums, Congregate Living Facilities for the Elderly, Hospitals, Residential Care Facilities for the Elderly, Residential Care Facilities for the Adults, Residential Care for the Developmentally Disabled**

Are the Insured facilities licensed? ☐ Yes ☐ No
If yes, by whom: ☐ California Department of Social Services, or ☐ ____________________________________________________.

**Occupancy**

| | No. of Beds Certified | Current Census | Level of Care | Current Census |
|---|---|---|---|---|
| Medicare/Medicaid | ☐ | ☐ | Skilled | ☐ |
| Private Pay | ☐ | ☐ | Intermediate | ☐ |
| Total Beds | ☐ | ☐ | Independent Living | ☐ |
| | | | Total Beds | ☐ |

Indicate the number of beds provided for residents with the following (included in the totals above)

Alzheimer/dementia ☐ chemical dependency ☐
HIV patients ☐ mental retardation/ mental illness ☐

Average census past 12 months for all residents: ☐
Describe other services:
Home health care? ☐yes ☐no Percentage (%) of ambulatory patients? ☐
Adult day care? ☐yes ☐no

**Employees**

***EMPLOYEE BREAKDOWN***

| | Full Time | Part Time | | Full Time | Part Time |
|---|---|---|---|---|---|
| Management | | | Physical Therapy | | |
| Clerical | | | Dietary | | |
| RN's | | | Maintenance | | |
| LPN's | | | Laundry | | |
| CNA's | | | Other | | |
| | | | Totals | | |

In past 12 months, how often has a Temporary Agency been used to meet staffing needs? ☐yes ☐no

**REFER TO BHHC SUPPLEMENTAL APPLICATION FOR NON - PROFITS**

Signed by:

Title:

Dated:



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