

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)	Ν	Non-Profit Organization	С	Conservatorship
2	Husband & Wife (Both names required in Legal Name.)	3	Joint Venture	Е	Estate
1	General Partnership	8	Public Agency	Т	Trust
 -	• • •			6	Association
L	Limited Partnership	Р	Incorporated Public Agency	J	Joint Employer
5	Corporation	9	Labor Union	А	Common Ownership
М	Non-Profit Corporation	U	Incorporated Labor Union	7	Other:

Section 3 – Licenses

Section 3 – Licenses	Section 4 – Additional Business Information
2101 Farm Labor Contractor License:	2075
	Phones: Bus. () Home ()
3405 Contractor's State License Board No./Type/Expiration Date:	2075
	FAX Number: ()
3408 PUC/ICC License Number:	2075
	E-Mail Address:
3409 Other License Numbers required to do business in CA (please specify):	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			8. Have any locations/operations for which coverage is not			
materials (e.g., power press)?			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?			
5. Provide meals or lodging in lieu of wages?			Please indicate:			
6. Pay any employees by the piece?						
7. Have any work at a maritime or offshore facility?						

Section 7 – Has the bus	siness or any principal o	f the busin	ess decl	ared bank	ruptcy in the las	st seven years? [Yes D No, skip to Section 8
Name of Principal:							
3105 Chapter of bankruptcy fi	iled (check as applicable):	□ 7	🗆 11	🗆 13	B 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 the	hat was purchased or acquired?						
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)? \Box No \Box Yes, Relationship:							
Have the operations changed since the business was acquired (e.g., from a bake	ry to a restaurant)? 🗌 No 🗌 Yes, please explain:						
Were more than 50% of the current employees hired since the acquisition?	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	J Vacations Paid Sick Leave						
Do you have a minimum of 2 employees?							
If yes, do you offer the majority of your eligible employees Health Insura							
If yes, do you pay at least 50% of the Health Insurance premium? \square N							
Please check off the hiring practices implemented by your company: J							
Pre-placement Drug Testing Drug-free Workplace Pre-em							
Do you have an Injury and Illness Prevention Program?							
Do you have a written early return-to-work program for employees injure	ed on the job? No Yes						
Do you document: Employee Training Facility Inspections							
Describe your housekeeping: Good Fair Poor Describ							
Have you received any OSHA citations within the past year? 🛛 No 🖓 Yes (Please explain in "Remarks.")							
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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.)

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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:	Please print	Title:	Please print
Signature:	(FAXed applications must be followed up with original document/signature.)	Date:	