CID
INSURANCE PROGRAMS, INC.

The Brokers Preferred Wholesale Solution

Workers' Comp - Healthcare

For a complete submission, please include the following information:

- ☐ ACORD Application 130
- ☐ Business FEIN #
- ☐ Supplemental Application
- ☐ 4 Years Currently Valued Loss History Regardless of Lapse in Coverage
  - If lapsed, provide date and reason
  - For new venture, provide date of first employee hire (loss runs not required)

If you don't see what you need or have any questions, please email your underwriter: Darby@CIDinsurance.com

Please submit completed application to:
Submissions@CIDinsurance.com
Attn: Darby Fisher
or fax to (619) 593-2008
Any questions, please call (800) 922-7283

CID Insurance Programs Inc. DBA CID Insurance Services

Healthcare Supplemental Application

(To be Completed with Acord 130 application)

NAMED INSURED	DBA	EFFECTIVE DATE	
ADDRESS	CITY	STATE	ZIP
WEBSITE ADDRESS	YEARS IN BUSINESS	ANNUAL REVENUE $	
ANY ADDITIONAL LOCATIONS? ○ YES ○ NO	IF YES, DESCRIBE		
STATES OPERATED IN			

EXPERIENCE

YEARS EXPERIENCE	OWNER	ADMINISTRATOR	DIRECTOR
YEARS AT FACILITY	OWNER	ADMINISTRATOR	DIRECTOR

DESCRIPTION OF OPERATIONS

○ ASSISTED LIVING FACILITY	○ HOME HEALTH CARE	○ NURSING HOME	○ MEDICAL STAFFING AGENCY
○ PROGRESSIVE LIVING HOME	○ VETERAN'S HOME	○ CHILDRENS HOME	○ DEVELOPMENT DISABLED HOME
○ SOCIAL SERVICES	○ GROUP HOME	○ ABUSE CENTER	○ OTHER
% OF RECEIPTS	PRIVATE PAY %	MEDICAID %	MEDICARE %

% OF PATIENTS WITH	HEPATITIS %	HIV %	ALZHEIMER/DEMENTIA %	MENTAL ILLNESS %	CHEMICAL DEPENDENCY %

PAY YOUR EMPLOYEES BY: W-2 ○ YES ○ NO % OF EMPLOYEES 1099 ○ YES ○ NO % OF EMPLOYEES CASH ○ YES ○ NO % OF EMPLOYEES

EMPLOYEE PROFILE

OCCUPATION	# FULL TIME	# PART TIME	AVERAGE ANNUAL PAYROLL
REGISTERED NURSES			$
LICENSED PRACTICAL NURSES			$
CERTIFIED NURSING ASSISTANT			$
HOUSEKEEPING / MAINTENANCE / LAUNDRY			$
DIETARY			$
OFFICE			$
OTHER (DESCRIBE)			$
VOLUNTEERS			ESTIMATED $

EMPLOYEE SECTION PROCEDURES

WRITTEN APPLICATION ○ YES ○ NO		PRE/POST-HIRE PHYSICAL ○ YES ○ NO	
INTERVIEW ○ YES ○ NO		REFERENCE CHECKS ○ YES ○ NO	
DRUG TEST ○ YES ○ NO		MVR REVIEW ○ YES ○ NO	
IS SICK TIME PROVIDED ○ YES ○ NO		IS VACATION TIME PROVIDED? ○ YES ○ NO	
ARE MEDICAL BENEFITS PROVIDED? ○ YES ○ NO		% ANNUAL EMPLOYEE TURNOVER %	
BACKGROUND CHECK ○ YES ○ NO			

COMPANY VEHICLES *(please provide company-owned vehicle list)*

# COMPANY VEHICLES	# OF DRIVERS	RADIUS OF OPERATIONS	
COMMERCIAL AUTO INS. CARRIER	LIABILITY LIMITS $	# OF EMPLOYEES TRAVELLING IN SAME VEHICLE	
ANY PERSONAL VEHICLES USED FOR COMPANY BUSINESS? ○ YES ○ NO		PROOF OF INS. OBTAINED	LIABILITY LIMITS $

PLEASE PROVIDE A COPY OF YOUR DECLARATION PAGE AND A VEHICLE SCHEDULE FROM YOUR AUTO POLICY.

Healthcare Supplemental Application

(To be Completed with Acord 130 application)

PLEASE COMPLETE ALL OF THE FOLLOWING

DO YOU HAVE A FORMAL SAFETY PROGRAM?	○ YES ○ NO
IS THE INSURED COMMITTED TO AN EARLY RETURN TO WORK PROGRAM?	○ YES ○ NO
DOES THE APPLICANT HAVE A SLIP AND FALL PREVENTION PROGRAM?	○ YES ○ NO
ANY DRUG/ALCOHOL ADDICTION COUNSELING OR SERVICES TO JAILS, CORRECTIONAL OR DETENTION CENTERS?	○ YES ○ NO
IN REVIEWING LOSS HISTORY OF THE APPLICANT, IS THERE ANY EVIDENCE OF VIOLENCE TOWARD STAFF OR RESIDENCE?	○ YES ○ NO
ARE SERVICES PROVIDED IN CITIES WITH A POPULATION GREATER THAN 200,000?	○ YES ○ NO
IS THE APPLICANT A NEW VENTURE OR AN ACQUISITION OF AN EXISTING OPERATION?	○ YES ○ NO
DOES THE APPLICANT HAVE A SAFE PATIENT HANDLING PROGRAM?	○ YES ○ NO
DOES THE APPLICANT HAVE A SEPARATE VOLUNTEER POLICY?	○ YES ○ NO

HOME HEALTH / ASSISTED LIVING SECTION

ANY SKILLED NURSING CARE? *(NOT INCLUDING BLOOD PRESSURE, TEMPERATURE, DISPENSING MEDICATIONS)*	○ YES ○ NO
IF YES, PLEASE DESCRIBE WHAT IS PERFORMED	

% OF CLIENTS	AMBULATORY	%	WHEELCHAIRS	%	REQUIRES ASSISTANCE GETTING IN/OUT OF BED, TUB, ETC.		%

DOES THE APPLICANT PROVIDE ANY TRANSPORTATION SERVICES FOR THE CLIENTS? *(DOCTOR APPOINTMENTS, SHOPPING, ETC.)*	○ YES ○ NO
DO VEHICLES THAT CARRY/TRANSPORT NON-AMBULATORY CLIENTS/PATIENTS USE A LIFTGATE?	○ YES ○ NO

ANY "LIVE IN" CARE OR 24 HOUR CARE?	○ YES ○ NO	IF YES, HOW MANY HOURS ARE THE SHIFTS?	HOURS

FOR ASSISTED LIVING	# OF BEDS	OCCUPANCY RATE % %

NURSING HOME SECTION *(if applicable)*

TOTAL # OF BEDS	# SKILLED NURSING BEDS	# INTERMEDIATE BEDS
# ASSISTED LIVING BEDS	# RESIDENTIAL CARE BEDS	OCCUPANCY RATE

NURSE TO PATIENT RATIO	1ST SHIFT	2ND SHIFT	3RD SHIFT

IS THIS FACILITY: ○ UNION ○ NON-UNION	STATE LICENSED? ○ YES ○ NO	SURVEY DATE

DOES THE APPLICANT PROVIDE ANY TRANSPORTATION SERVICES FOR THE CLIENTS? *(DOCTOR APPOINTMENTS, SHOPPING, ETC.)*	○ YES ○ NO
DO VEHICLES THAT CARRY/TRANSPORT NON-AMBULATORY CLIENTS/PATIENTS USE A LIFTGATE?	○ YES ○ NO

LIST ALL RESIDENT TRANSFER AIDS

TYPE OF DEVICE	#	TYPE OF DEVICE	#

Note: All information provided for the purpose of securing insurance coverage is subject to underwriting verification, an underwriting survey and/or inspection. You must notify us of any significant change in operations or payroll. Terms may be rescinded, or coverage cancelled if any person knowingly conceals information, and/or provides any inaccurate or materially false information for the purpose of obtaining insurance coverage.

Signature of Applicant: _____ Date: _____

Please submit completed ACORD 130 & Supplemental application to submissions@cidinsurance.com.