RYAN TURNER SPECIALTY

RT WC Specialty

Group Home & Social Service Product

Supplemental Workers' Compensation Application

Insured Name: This

Insured Web Address: test

Insured FEIN: sdrastas

Payroll/Premium Information:

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

Business Operations

Please provide a detailed description of the operation:

_____

List the Applicant's State of Operation:

☐ For Profit ☐ Not for Profit ☐ Partnership ☐ Other

If other, please specify : _____

1. Are medical/health insurance benefits provided to employees? ◯ Yes ◯ No

2. Are at least 60% of the insured's staff professional employees? ◯ Yes ◯ No

3. Is 24-hour staffing provided? ◯ Yes ◯ No

4. Indicate percentage of volunteers in the workforce:

☐ 0% ☐ 1 – 10% ☐ 11 – 40% ☐ >40%

5. Does the Insured have a Residential Housing Facility? ◯ Yes ◯ No

6. Does the Insured have a formal safety program? ◯ Yes ◯ No

7. Does the insured complete drug testing prior to employment and post accident? ◯ Yes ◯ No

8. Does the insured complete a criminal background check? ◯ Yes ◯ No

9. Does the insured complete a child abuse clearance check? ◯ Yes ◯ No

Business Operations (Check all that apply):

☐ Mental Health Counseling	☐ Substance Abuse Counseling	☐ Residential/Group Homes
☐ Foster Care Provider	☐ Secured/Lockdown Facilities	☐ Shelters
☐ Vocational Training/Programs	☐ Crisis Response Team	☐ Adult Day Care
☐ Physical/Occ. Health Therapy	☐ Drug Treatment/Detox	☐ Health Clinics

Please indicate where your employees perform their work:

☐ Private Homes/Apartment	☐ Clinics	☐ Group Homes
☐ Shelters	☐ Hospitals	☐ Corporate Officers
☐ Day Care Setting	☐ Job Coaching	☐ Other Locations

***If other, please specify**:* _____

*** The undersigned attests that all information provided is both accurate and truthful. All information provided is subject to verification by way of an underwriting survey or inspection. You must notify RT Specialty of any significant change in operations or payroll. Terms of insurance coverage may be canceled for misrepresentation if information provided is inaccurate.***

Signature of Applicant: _____

Title: _____

Print Name: _____ Date: _____