

**This section must be completed by all applicants who are individuals, sole proprietorships, husband and wife, or partnerships (where the general partners are husband and wife).**

Please list below any relatives residing in your household who are employees of your business and to whom your books and records show payments to such relatives:

Employed Relatives*			
Name	Relationship to You	Job Title or Duties	Estimated Annual Remuneration

Check here if there are no relatives residing in your household that are employed in your business.

**\*Relatives are defined as: spouse, child by birth or adoption, stepchild, grandchild, son-in-law, daughter-in-law, parent, step-parent, parent-in-law, grandparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, sister-in-law, uncle, aunt, nephew, or niece.**

**Note:** Per California Labor Code, as an employer you are required to include in your Workers' Compensation coverage all relatives residing in your household who are your employees. Any policy issued based on information provided in this application will exclude coverage for residing relatives if none are listed above.

**Note:** All information provided is subject to verification by way of an underwriting survey or inspection. Arrowhead General Insurance Agency, Inc. must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Signature of Applicant:	Date:
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**HEALTH AND HUMAN SERVICES**

Is applicant a licensed facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
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Is operation accredited by CARF (Commission on Accreditation Rehabilitation Facility)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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Is group transportation provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, number of company vehicles:	Number of personal vehicles:
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Percentage of group transportation subcontracted? _____ % <input type="checkbox"/> N/A
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Any off-site activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details:
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Does applicant offer "live-in" employees at client's residence/premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what percentage?
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Are certificates of insurance obtained from all subcontracted operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Average # of certificates collected annually? _____
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Does risk have a written Blood Borne Pathogen Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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Does this risk treat for HIV and/or AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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Does risk have patient/resident handling/lifting equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Does risk have written patient/resident handling protocols? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Does risk provide ongoing In-Service Training? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often?
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Provide percentage of residents/patients: Ambulatory: _____ Non-Ambulatory: _____ <input type="checkbox"/> N/A
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Does risk provide food service? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide details:
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Does risk have volunteers? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If yes, provide details (number of volunteers, duties performed, etc.):
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Indicate % of operations in each of the following categories or mark not applicable -  N/A

Abortion Clinic:	Acupuncture/Acupressure:	Blood banks/Donor Clinic:	Drug/alcohol Treatment Clinic:
Family Practice:	Industrial Clinic:	Med Lab/testing:	Specialist:
Mobile Operation:	Urgent Care Clinic:	Walk-in Clinic:	Weight Control Clinic:
Other:			

Indicate % of operations in each of the following categories or mark not applicable -  N/A

Physicians/MD:	PhD:	Psychiatrist:	Psychologist:
Physicians Asst.:	Nurse Practitioner:	Registered Nurse:	Licensed Voc. Nurse:
Cert. Nurses Asst.:	Social Worker:	Counselor:	Dietary:
Dentists/ Surgeons:	Registered Dental Asst.:	Dental Hygienist:	Chiropractor:
Physical Therapist:	Physiotherapist:	Occupational Therapist:	Administrative:

If organization is a day care center or provides day care operations indicate the %: Children age up to 1yr: _____ 1-3yrs _____ 3-5yrs _____
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Maximum enrollment:	Number of currently enrolled children:
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Provide ratio of child-care staff to children: <input type="checkbox"/> 1 to 2 <input type="checkbox"/> 1 to 3 <input type="checkbox"/> 1 to 4 <input type="checkbox"/> Other, explain:
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Is the operation based out of a home residence? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If operation provides veterinary services please provide %: Domestic/Household pets _____% Farm animals _____% Exotic/Wild _____%
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Provide details:

Provide % of the following:	Grooming: _____ %	Kennel: _____ %	Boarding: _____ %
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Any field or off-site services provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details:
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