

Franchise Residential Cleaning Services

Workers Comp Supplemental Application – 7/2018 Edition

(Complete & Submit with Acord 130 Application)

Applicant Name: _____	Eff Date: _____
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Fein #: _____	Website Address: _____
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SAFETY PROGRAM – WORK PREMISES, ENVIRONMENT, AND BENEFITS

Are owners active in daily operations?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, are they excluded from coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Corporation – Does Officer or Director have 15% minimum ownership?		Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	
Partnership or LLC – Is the excluded person a General Partner or Managing Member?		Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	
Active formal written Safety Program?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Active safety incentive program?		Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, does it include all employees? Yes <input type="checkbox"/> No <input type="checkbox"/>
What type of incentive? _____		Average Hourly Wage? _____	
Do employees receive safety orientation & training?		Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, is the training – Formal/Documented <input type="checkbox"/> Informal <input type="checkbox"/>
Are safety meetings conducted?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	
Return to Work Program/Modified Duty?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please describe _____	
Doe Employer Provide Group Medical?		Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Name of Provider? _____

HIRING PRACTICES

Written Employment Application?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pre Hire Drug Testing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Reference Checks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	I9 Verification on All New Hires?	Yes <input type="checkbox"/> No <input type="checkbox"/>
MVR Checks?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Are Driver Acceptability Standards in Place?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, Please Provide Details: _____			

RESIDENTIAL CLEANING SERVICES

* **Includes** operations such as vacuuming, dusting, wastebasket trash pick-up, floor & rug cleaning, restroom clean-up

Services Provided:			
<input type="checkbox"/> General Cleaning *	<input type="checkbox"/> Carpet Cleaning	<input type="checkbox"/> Floor waxing	<input type="checkbox"/> Exterior Window Cleaning – Over single story
<input type="checkbox"/> Manual Lifting or Moving > 25 Lbs?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Please describe: _____	
<input type="checkbox"/> Exterior Cleaning Services?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Please Describe: _____	
Any Cleaning Supplies Used Other Than Standard Household?		Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Please Describe: _____
		If Yes, MSDS Available?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do Employees Work in Teams?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Average # of EE's per Team? _____	Maximum # of EE's per Team? _____
Use Co Owned Vehicles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vehicles Taken Home? Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	Family Use Policy? Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Do Employees Use Personal Vehicle?		Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	Require Proof of Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Inspect Personal Vehicles?	Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>	If Yes, How Often? _____	Proof of Maintenance? Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Driving Guidelines for Cell Phone Usage & Seatbelts?		Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Please describe: _____
Hours of Operation: _____ to _____		Average # of Jobs per Day? _____	Radius of Operations: _____

Completed by: _____	Date: _____	Email Address: _____
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