PARAGON Insurance Holdings

Description of Operations, Hiring, Employment & Safety Characteristics

Applicant Name ______________________ **Proposed Effective Date** ______________________

FEIN ______________________ **Company Website** ______________________

Description of Operations

Misc. (Explain any gaps in coverage, cancellations, significant fluctuations in payroll, etc.)

Employee Breakdown (Top Classes by Payroll Excluding 8810/8742)

Class Code	# FT	# PT	# Seasonal	# Other	Union?	Avg. Wage Per Hour
					[ ] Yes [ ] No	
					[ ] Yes [ ] No	
					[ ] Yes [ ] No	
					[ ] Yes [ ] No	

Hiring Practices
Check Yes ONLY if Applicable to 75%+ of Labor

[ ] Yes [ ] No	Written Application
[ ] Yes [ ] No	Written Job Description
[ ] Yes [ ] No	Background/Reference Check
[ ] Yes [ ] No	Pre-Hire Drug Testing
[ ] Yes [ ] No	Pre-Hire Physical Fitness Test

Safety Practices
Check Yes ONLY if Applicable to 75%+ of Labor

[ ] Yes [ ] No	Formal Injury & Illness Prevent. Plan
[ ] Yes [ ] No	Formal Return to Work Plan
[ ] Yes [ ] No	Quarterly (or More) Safety Meetings
[ ] Yes [ ] No	Quarterly (or More) Safety Training
[ ] Yes [ ] No	Safety Incentive Plan

Management Practices, Loss Control, Claims Handling & Benefits

[ ] Yes [ ] No	Is the ownership active in the day-to-day operations of the company?
[ ] Yes [ ] No	Is there a full-time risk/safety manager employed whose job is 50%+ safety related?
[ ] Yes [ ] No	Is there a formal and random drug testing program for all employees?
[ ] Yes [ ] No	Is there a formal post-accident drug testing program for all workplace injuries?
[ ] Yes [ ] No	Upon termination are personnel files documented for any potential workplace injuries?
[ ] Yes [ ] No	Is there a formal accident investigation and claims reporting process?
[ ] Yes [ ] No	Do more than 50% of employees receive group health through you that is 50%+ employer paid?

Details / Descriptions / Notes

Business Operations

Management	
____________ #	Number of years this facility has been operating?
____________ #	Number of years owned by present owner?
____________ #	Number of years owned by present management?
[ ] Yes [ ] No	Is this facility owned by an outside management company?
[ ] Yes [ ] No	Is this facility owned or leased by a multi-facility operator?

Staffing	# of Professional	# of Non-Professional Employees
Management		
Clerical (non-management)		
Home Health Aides *		
Personal or Home Care Aides **		
LPN's		
RN's		
Nurse Practitioners		
Physical Therapists		
Respiratory Therapists		
Speech Therapists		
Occupational Therapists		
Physicians Assistants		
Nurse Anesthetists		
Social Workers		
Other:		

[ ] Yes [ ] No	Does this company operate as a staffing agency for medical offices, hospitals or nursing homes?
[ ] Yes [ ] No	Do employees work between the hours of 8:00 p.m. and 6:00 a.m.?
[ ] Yes [ ] No	Do employees work consecutive 24-hour shifts?

Definitions

<u>*Home Health aides</u> typically work for certified home health or hospice agencies under the direct supervision of a medical professional, usually a nurse. They maintain records of services performed and of clients' condition and progress and report changes in the client's condition to the supervisor or case manager. They may provide some basic health-related services, such as checking patients' pulse rate, temperature, and respiration rate. They also may help with simple prescribed exercises and assist with medications administration. Occasionally, they change simple dressings, give massages, provide skin care, or assist with braces and artificial limbs. With special training, experienced home health aides also may assist with medical equipment.

<u>Personal and home care aides (also called homemakers, caregivers, companions and personal attendants)</u>** work for various public and private agencies that provide home care. These caregivers are likely supervised by a licensed nurse, social worker, or other non-medical manager. They typically work independently, with only periodic visits by supervisors. Aides may work with those that are developmentally disabled.

Business Operations

Patient Safety/Mobility Operations	
	Check all that apply
Powered Sit to Stand	
Standing Assist Devices	
Lateral Transfer/Repositioning	
Trapeze Bars/ Hand Blocks	
Bathtub, Shower, Toilet Devices	
Portable Lift Devices	
Ambulation Assist Devices	
Electric Adjustable Beds	
Pelvic Lift Devices	
Push up Bars	
Ceiling Mounted Lifting Devices	
Other (please describe):	

Daily Patient Operations	
	Total to 100%
Bathing Patient	
Pharmaceutical Administration	
Administering of medication via IV	
Laundry	
Light Cleaning	
Cooking/Meal Prep	
Driving Patient/ Shopping for Patient	
Driving to other Sites (other patient)	
Transfer patient in/out of bed	
Mobility/Physical Activity	
Dressing Patient/Hygiene	
Other (please describe):	

Compensation		
	Method of Compensation	Average Wage
Non-Professional Staff	[ ] Salary [ ] Hourly [ ] Per Visit [ ]Other	$_________per _____________
Professional Staff	[ ] Salary [ ] Hourly [ ] Per Visit [ ]Other	$_________per _____________

Safety Program- check any that apply		
[ ] Personal Protective Gear Worn	[ ] Combative Patient Training	[ ] Safety Committee
[ ] Lifting Procedures and training	[ ] Blood Borne Pathogen Training	[ ] New Employee Orientation
[ ] Sharps disposal (OSHA compliant)	[ ] Contaminated Waste/Hazardous products disposal (OSHA compliant)	[ ] Other (please describe):

Signature & Affirmation

By signing this application the client is acknowledging that all information provided on all pages of this supplemental application are complete and accurate representations of work and processes as of the date this application is signed. Additionally, by requesting insurance products through our company you and the client agree to notify us immediately regarding any change in operations that would result in a change in any of the answers provided on this application. All information is subject to verification. Any insurance policy issued may be cancelled, subject to applicable local law, for misrepresentation if the information provided here is not accurate.

Signature of Applicant ____________________ Date Signed ____________________

Signature of Agent ____________________ Date Signed ____________________