Key Risk
| a Berkley Company

COVID-19 Healthcare

Workers Compensation
Supplemental Application

Employer Name: _____

Website: _____ Phone Number: _____

Primary Contact: _____ Email: _____

Address: _____

Description of Operations: _____

_____

Payroll, Premium & Experience Mod History

Please fill in the correct amount for each of the following:

Category	Expiring Year	Prior (1)	Prior (2)	Prior (3)	Prior (4)
Payroll					
Premium					
Experience Mod					

General Information

1. Do you have an individual assigned to manage your infection control program? ☐ Yes ☐ No

   If yes, what is their name and title? _____

2. Do you have written policies and procedures in place that would trigger the implementation of protective measures for employees? ☐ Yes ☐ No

3. Do you have patients currently testing positive for COVID-19? ☐ Yes ☐ No

   If yes, how many? _____

4. Do you have employees currently testing positive for COVID-19? ☐ Yes ☐ No

   If yes, how many? _____

5. When testing patients and healthcare personnel for COVID-19 what is your average turnaround time for results?

   _____

6. Do you have a non-punitive sick leave policy to prohibit potentially contagious staff from working? ☐ Yes ☐ No

7. Do you provide additional training to staff on hand washing and personal protective equipment (PPE) related to the Covid-19 pandemic? ☐ Yes ☐ No

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8. Do you have health screening measures for personnel at the beginning of their shift during a pandemic? ☐ Yes ☐ No

9. Are employees required to wear isolation/surgical masks at all times? ☐ Yes ☐ No

10. Do you have N-95 masks available for use when providing high risk care such as trachea/respiratory treatments? ☐ Yes ☐ No

11. Have you experienced a shortage of PPE during a pandemic? ☐ Yes ☐ No

12. How many weeks of PPE (masks/gloves/face protection/gowns) do you maintain on your premises?

_____

13. What is your protocol for employees who have known or suspected COVID-19 exposure or infection?

_____

_____

14. Are employees required to be vaccinated for COVID-19? ☐ Yes ☐ No

15. What percentage of your employees have received the vaccination? _____

Applicant Signature

Notice: This application is for the purpose of obtaining a quotation and does not bind the applicant or the Company to provide the insurance. The Undersigned declares that to the best of his/her knowledge, the statements set forth herein are true. If the information supplied herein changes between the date completed and the effective date of the insurance, the undersigned shall notify the Company of the changes and the Company reserves the right to modify or withdraw any offer for insurance.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or, conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject such person to criminal and civil penalties.

Applicant Name: _____ Title: _____

Applicant Signature: _____ Date: _____