

Social Services EZ Quote Form

New Mexico Mutual 3900 Singer Blvd. NE Albuquerque NM 87109

Completed By:	In addition to the supplemental information, please attach the following if applicable: <ul style="list-style-type: none"> • 3 to 5 Year Currently Valued Loss Runs • Associated Premium Figures • Experience Rating Worksheet
Title:	
Date:	

General Information																									
Company Name:	FEIN:																								
Number of years experience in this industry:	Number of years managing in this industry:																								
Type of company: <input type="checkbox"/> For Profit <input type="checkbox"/> Not For Profit																									
Business Operations: (Please Check All that Apply) <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Adult Day Care</td> <td><input type="checkbox"/> Group Homes (i.e. Permanent)</td> <td><input type="checkbox"/> Schools</td> </tr> <tr> <td><input type="checkbox"/> Child Day Care</td> <td><input type="checkbox"/> Group Therapy</td> <td><input type="checkbox"/> Shelters (i.e. Temporary)</td> </tr> <tr> <td><input type="checkbox"/> Church</td> <td><input type="checkbox"/> Home Health Care</td> <td><input type="checkbox"/> Substance Abuse Counseling</td> </tr> <tr> <td><input type="checkbox"/> Community Association</td> <td><input type="checkbox"/> Job Coaching</td> <td><input type="checkbox"/> Thrift Stores</td> </tr> <tr> <td><input type="checkbox"/> Contract for Work for Gov't Entities</td> <td> <input type="checkbox"/> On Premises <input type="checkbox"/> Off Premises </td> <td><input type="checkbox"/> Vocational Training</td> </tr> <tr> <td><input type="checkbox"/> Detention Facilities</td> <td><input type="checkbox"/> Meals on Wheels</td> <td><input type="checkbox"/> Workforce Participation</td> </tr> <tr> <td><input type="checkbox"/> Drug Treatment/Detox</td> <td><input type="checkbox"/> Mental Health Counseling</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Food Bank</td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Group Homes (i.e. Permanent)	<input type="checkbox"/> Schools	<input type="checkbox"/> Child Day Care	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Shelters (i.e. Temporary)	<input type="checkbox"/> Church	<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Substance Abuse Counseling	<input type="checkbox"/> Community Association	<input type="checkbox"/> Job Coaching	<input type="checkbox"/> Thrift Stores	<input type="checkbox"/> Contract for Work for Gov't Entities	<input type="checkbox"/> On Premises <input type="checkbox"/> Off Premises	<input type="checkbox"/> Vocational Training	<input type="checkbox"/> Detention Facilities	<input type="checkbox"/> Meals on Wheels	<input type="checkbox"/> Workforce Participation	<input type="checkbox"/> Drug Treatment/Detox	<input type="checkbox"/> Mental Health Counseling	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Food Bank		
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Please provide a description of programs and services, and include the applicant's website. 																									
Please advise where services are provided. (i.e. applicant's premises, client's premises) 																									
Are volunteer's used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many volunteers are used? _____																									

Are overnight accommodations provided for employees? ☐ Yes ☐ No

If yes, what is the frequency and duration of the overnight stay?

☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

What is the number of company owned vehicles? _____ ☐ N/A

Is group transportation provided (4 or more per vehicle)? ☐ Yes ☐ No

If yes, how often?

☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

What is the radius of operations? Usual: _____ miles Maximum: _____ miles

Is there any foreign travel exposure? ☐ Yes ☐ No

If yes, is there a foreign workers compensation policy in place? ☐ Yes ☐ No

Employee Information

How many employees are on staff: Full Time: _____ Part Time: _____

How are employees paid?

☐ W-2's ☐ 1099's ☐ Cash ☐ Other: _____

What percentage of the work is subcontracted? _____%

If subcontractors are used, are Certificates of Insurance obtained? ☐ Yes ☐ No ☐ N/A

* Please note: Premiums must be paid on uninsured subcontract labor *

If certificates are not obtained, what amount of payroll should be added for uninsured contract labor?

- Class Code: _____ Payroll: _____
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Please check all hiring practices utilized by the applicant:

- | | |
|---|---|
| <input type="checkbox"/> Applicant Interviews | <input type="checkbox"/> Post-Offer Physicals |
| <input type="checkbox"/> Background Checks | <input type="checkbox"/> Reference Checks |
| <input type="checkbox"/> Drug Testing/Screening | <input type="checkbox"/> New Employee Orientation |
| <input type="checkbox"/> Medical Questionnaires | <input type="checkbox"/> Other: _____ |

Safety Information															
Is a safety program utilized in the workplace? <input type="checkbox"/> Yes <input type="checkbox"/> No															
If yes, is the program? <input type="checkbox"/> Written <input type="checkbox"/> Verbal															
Does the safety program address/include: (Please Check All that Apply) <table border="0"> <tr> <td><input type="checkbox"/> Accident/Injury Investigation</td> <td><input type="checkbox"/> Progressive Disciplinary Action Plan</td> </tr> <tr> <td><input type="checkbox"/> Aggressive Patient Training</td> <td><input type="checkbox"/> Return to Work Program</td> </tr> <tr> <td><input type="checkbox"/> Blood Borne Pathogen Protocol</td> <td><input type="checkbox"/> Safety Committee/Safety Officer</td> </tr> <tr> <td><input type="checkbox"/> In-service Training</td> <td><input type="checkbox"/> Safety Incentive Program</td> </tr> <tr> <td><input type="checkbox"/> Medical Waste Disposal Program</td> <td><input type="checkbox"/> Safety Orientation</td> </tr> <tr> <td><input type="checkbox"/> Patient Handling/Lifting Training</td> <td><input type="checkbox"/> Third Party Safety Company</td> </tr> <tr> <td><input type="checkbox"/> Personal Protective Equipment</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>		<input type="checkbox"/> Accident/Injury Investigation	<input type="checkbox"/> Progressive Disciplinary Action Plan	<input type="checkbox"/> Aggressive Patient Training	<input type="checkbox"/> Return to Work Program	<input type="checkbox"/> Blood Borne Pathogen Protocol	<input type="checkbox"/> Safety Committee/Safety Officer	<input type="checkbox"/> In-service Training	<input type="checkbox"/> Safety Incentive Program	<input type="checkbox"/> Medical Waste Disposal Program	<input type="checkbox"/> Safety Orientation	<input type="checkbox"/> Patient Handling/Lifting Training	<input type="checkbox"/> Third Party Safety Company	<input type="checkbox"/> Personal Protective Equipment	<input type="checkbox"/> Other: _____
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Does the insured perform regular safety training? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, identify the frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Other: _____															
Please identify the individual responsible for safety training and their title: Name: _____ Title: _____															

Thank you for completing New Mexico Mutual's Underwriting EZ Quote Form. Please return this form to your assigned underwriter and we will review your account for our best pricing options.