



P.O. Box 2359, San Francisco, CA 94126
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**COLLECTIVELY BARGAINED WORKERS'
 COMPENSATION PROGRAM
 (ADR/Alternative Dispute Resolution)**

www.majesticinsurance.com

SUPPLEMENTAL QUESTIONNAIRE

The employer must be signatory to a collective bargaining agreement with a union or unions that have established a collectively bargained workers' compensation insurance program that meets regulatory requirements under California Labor Code 3201.5.

Insured Names(s)

EMPLOYER CONTACTS	NAME	TELEPHONE	E-MAIL
HR			
SAFETY			
CLAIMS			
FINANCIAL			

Is the employer currently participating in a Collectively Bargained Workers' Compensation Program? YES/NO
 If YES, name the program or trust and list percentage of total payroll subject to the program(s). Please attach a copy of the MEMORANDUM OF UNDERSTANDING, PARTICIPATION AGREEMENT, or similar documentation showing participation eligibility.

	% Payroll
Program/Trust	
Program/Trust	
Program/Trust	
Program/Trust	

Total estimated annual payroll for the next 12 months: _____
 Estimated % of payroll to be reported to the program(s) or trust(s): _____

The DWC requires an annual report of estimated payroll/hours by classification code that will be reported to the program(s)/trust(s) during the policy period. Please exclude payroll for partners, executives and administrative payroll.

CLASSIFICATION CODE	DESCRIPTION	PROGRAM/TRUST	ESTIMATED ANNUAL PAYROLL

Prepared by _____ Title _____ Date _____