Reset Form Print Form

Payroll and Employee Count Supplemental

To provide you with accurate pricing, we need to gather additional information about your operations, including your payroll and employee count estimates for the proposed policy term. This information will help us finalize your pricing. Please provide complete responses to the questions below.

Section 1 – Employer Information

Name/Title of Person Completing Form	
Name of Business	
Mailing Address	
Website	
Email	

Section 2 – Description of Operations

Please explain the services your business provides to your customers. Include the type of customers you provide services to, as well as the tools you use to perform those services. If you provide a service that is different from other employers engaged in similar services, please explain. If your operation has a seasonal aspect to it, please explain and define your typical season (i.e. month of operation):

How many hours a day do you operate? _____
How many days a week do you operate? _____
How many shifts do your employees work per day? _____ Please provide details below:

Section 3 –Independent Contractors (1099), Contractor Workers, Vendors (Any Non-Employee Performing Work for Your Business)

Do you hire independent contractors, contract workers, or vendors to perform any services for your business?

Yes ☐ No ☐

If yes, please complete the information below and include a copy of the contract with your independent contractors, contract worker, or vendor with your response:

© 2026 State Compensation Insurance Fund

Please indicate how the business work of is performed below:

Type of work Performed	What % of work is performed by employees	What % of work performed by Independent Contractors, Contract Workers or Vendors- others (non-employees)?	How much do you pay independent contractor, vendor or contract worker per job or contract?

Section 4 – Subcontractor

Do you hire subcontractors to perform any services for your business? **Yes ☐ No ☐**
If yes, please provide details for the work subcontracted out below:

Name of Subcontractor	Please include the Worker's Compensation Policy Number and name of carrier for each Subcontractor	Please include CSLB License Number for each Subcontractor	Please include the % and type of work subcontracted to others (non-employees)	What is the cash value of the total subcontracted work for each subcontractor?

© 2026 State Compensation Insurance Fund

Section 5 – Payroll, Payments and Gross Receipts

Please provide information below to include payroll, payments to subcontractors, cash labor payments, and gross receipts for past and current years of operation. How much do you think you paid or will pay in the following categories

How much do you think you paid or will pay?	Direct/W2 Payroll	1099/Subcontractor Payments	Annual Cash Labor	Gross Receipts
Next 12 Months	$	$	$	$
Current year	$	$	$	$
Prior Year	$	$	$	$

Do you make any payments to your vendors, subcontractors or employees using electronic payment applications (e.g. Zelle, Venmo, CashApp, PayPal, etc.)? ☐ **Yes** ☐ **No** If YES, please advise if the electronic payments are included above. If not, please explain why:

Section 6 – Employees & Payroll

Complete the table below. (California State Labor Code 515(c) defines full time hours as 40 hour per week, and employees working less than 40 hours a week are defined as part-time workers):

Job Duties	Full-Time Employees* (≥ 1500 Hours per Year)			Part-Time Employees (< 1500 Hours per Year)		
	Number of Full-Time	Hourly Wage Rate	Hours Worked (Per Week)	Number of Part-Time	Hourly Wage Rate	Hours Worked (Per Week)

*A Full-Time Employee is defined as working 1500 hours or more annually. Anyone working less than 1500 hours per year is a Part-Time Employee.

© 2026 State Compensation Insurance Fund

Do you employ or work with any of the following? Please complete the information for each Labor type noted:

Labor Type (Non W2)	Yes	No	If yes, indicate how many for each labor type below.	Provide monthly payment or compensation value below.	Was payment or compensation included in your total estimated annual payroll?	
					Yes	No
Day/Casual Labor	☐	☐			☐	☐
Family members/Relatives	☐	☐			☐	☐
Volunteers	☐	☐			☐	☐
Employees from Labor Brokers	☐	☐			☐	☐
Other:	☐	☐			☐	☐

Do you pay any type of allowances, per diem or lodging? ☐ Yes ☐ No If YES, please explain:

Do you provide any non-cash/non-payroll compensation? ☐ Yes ☐ No If YES, please explain:

Name of Owner(s)/Officers

Payroll information and job duties for covered owner(s), officers, partners, managers, or members. Include all supervisory or oversight duties:

Name	Title	Detailed Job Duties	Annual Payroll/Compensation

Section 7 – Other Businesses Not Reflected Above

List all businesses that any owner/officer has any affiliation, interest, or ownership with below:

Business Name	Name	Title	Ownership %

© 2026 State Compensation Insurance Fund

PEO/Temporary Staffing Agency

Please answer the following questions if applicable	Yes	No
Do you obtain or intend to obtain any workers from a staffing agency, Labor Contractor or PEO?	☐	☐
Do you obtain or intend to obtain workers from another employer?	☐	☐

If you reduced your workforce or no longer have employees engaged in the daily work associated with your business operations, **explain** who is performing the daily work (construction, security work etc. excluding clerical or outside sales employees):

Construction RMO/RME/RMM

Does your Responsible Managing Officer/Responsible Managing Employee/Responsible Managing Member work for any other business affiliated or not affiliated with this employer? ☐ Yes ☐ No

If YES, provide the name of the businesses including the CSLB license number(s) they work for and clarify any affiliation below:

Is the payroll for the RMO/RME/RMM included in the total annual payroll amounts? ☐ Yes ☐ No

Please indicate the payroll amount for the RMO/RME/RMM:

If any of the information provided changes during the policy year, please contact us to provide updates to ensure that the policy information is accurate.

Fraud Warning/Fraud Statement

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or make a claim for payment of a loss is guilty of a crime and may be subject fines and confinement in state prison.

This supplemental must be signed and dated by a Principal Owner, Senior Officer, Partner, Managing Member of the business. Electronically reproduced signatures will be treated as originals

Employer Printed Name: _____ **Employer Signature**_____

Title: _____ **Date:** _____

I (we) hereby declare that all of the information contained in this questionnaire is correct and complete to the best of our knowledge, that the questionnaire was completed and personally signed by the applicant or policyholder, and that a completed copy hereto has been given to the applicant.

Additional signature required for Brokered applications or policies.

Name of Producing Agency_____ **Signature of Producing Agent**_____

Date_____

© 2026 State Compensation Insurance Fund