

WORKERS COMPENSATION SUPPLEMENTAL APPLICATION

NAMED INSURED _____ Policy Effective Date _____

OWNERS: Active Absentee Delegate through supervisors
 Years in Business _____ Years of Experience – same industry: _____
 Other currently owned businesses which are separately insured? Yes No
 If yes, identify these entities and explain any interchange of labor with these different affiliates: _____

OPERATIONS: Hours of Operation: _____ to _____ Number of days per week: _____

Overtime: None Occasionally Often

Percentage of work subcontracted: _____ % Type of work subcontracted: _____

Are Certificates of Insurance, evidencing WC coverage, required and obtained from all subcontractors? Yes No

Describe any other physical or contractual controls in place over subcontractors: _____

Do you lease workers? Yes No

If yes, describe type of labor leased and identify leasing company: _____

Who is responsible to provide Workers Compensation coverage to leased workers? Leasing Co. You

Do you lease workers to others? Yes No If yes, explain: _____

If yes, who is responsible to provide Workers Compensation coverage to leased workers? Client Co. You

Vehicle and Driving Exposure:

Identify number of company vehicles ___ PPTs ___ P/Us ___ Med. & Heavy Trucks ___ Tractors _____

Number of regular drivers of company vehicles: _____

Number of employees who regularly drive their own vehicles on company business: _____

Percent of travel that exceeds a 150 mile radius? _____ %

Are Motor Vehicle Records (MVRs) checked on all company drivers? Yes No

If No, explain: _____

Total number of employees: Full Time: _____ Part Time: _____ Seasonal: _____ Union? Yes No

Governing Classification Wages: Starting: \$ _____ Average: \$ _____

Estimated % of employees the Insured has employed for less than one year: _____ %

Any employees in a monopolistic state (ND, OH, WA, WV, WY)? Yes No Which State(s)? _____

If yes, how many employees are in these states? _____

Do job duties include travel outside the United States? Yes No If yes, describe:

of employees who travel overseas each year _____

Average frequency of travel each year for those employees who travel overseas _____

Average duration of trips overseas _____

Identify countries involved _____

Does Insured have employees exposed to any of the following types of operations or activities:

Commercial delivery of letters or packages Food or Beverage processing or packaging Water Treatment Plants

Please Explain: _____

PAYROLL INFORMATION:

<u>Policy Term</u>	<u>Total Payroll</u>	<u>Total Premium</u>	<u>Audited Payroll</u>
2002/2003 estimated	\$ _____	-----	-----
2001/2002 expiring yr.	\$ _____	\$ _____	-----
2000/2001	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1999/2000	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1998/1999	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1997/1998	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

HIRING AND EMPLOYMENT PRACTICES:

Pre-Hire Physicals Yes No Complete Application Yes No
Post-Hire Physicals Yes No References Checked Yes No
Pre-Hire Drug Screen Yes No Random Drug Testing Yes No
Drug/Alcohol Rehab Program Yes No Return to Work Program Yes No
Written Personnel Procedures Yes No

BENEFITS:

Group Medical: Yes No Eligible employees: Full Time only All employees, including Part Time
Percent Paid by Employer: _____%

Disability Insurance provided? Yes No Paid sick days? Yes No
Other Benefit Programs: _____

WORKERS COMPENSATION MEDICAL PROVIDER:

Clinic Physician Emergency Room

Does the Insured use a specific medical provider or network to treat injured employees? Yes No
If yes, please identify the provider or network: _____

LOSS CONTROL AND SAFETY

Risk Manager Yes No Full Time Part Time
Safety Director Yes No Full Time Part Time

Name and title of person(s) responsible for safety: _____

Written Safety Program? Yes No
Safety Incentive Program? Yes No Is compensation to supervisors adjusted based on safety record? Yes No

Does the Insured require immediate Loss Control or Engineering services? Yes No
Is Insured willing to implement loss control recommendations made by the insurer? Yes No
Are supervisors trained in safety education? Yes No If yes, how frequently? _____
Safety meetings held regularly with employees? Yes No If so, how often?
 Weekly Monthly Quarterly. Semi-Annual
Accident review program? Yes No Hazard identification training? Yes No
Hazardous Materials Communication program in place? Yes No
Describe equipment used: State of Art Standard for Industry Modified to Standard
Equipment inspection/maintenance program? Yes No If yes, describe: _____
Any ergonomic concerns with your equipment or machinery now or in the past? Yes No If yes, please describe:

Machine guarding exposure: All Properly Guarded Partially Guarded* Minimal/No Guarding *
*Describe machinery or equipment lacking guarding: _____

Lock Out/Tag Out program in place? Yes No
Personal Protective Equipment: Required Recommended Not Required or Recommended
Describe personal protective equipment used: _____
Lifting Exposure: Less than 10 pounds 11 to 40 lbs. 40 to 60 lbs. Over 60 lbs.
Describe lifting and any mechanical aids: _____
Formal safe lifting training or program ? Yes No

Does Insured conduct periodic Fire and Emergency Evacuation drills? Yes No
During these drills does the insured account for all employees Yes No
Has Insured reviewed US Postal Service guidelines for handling suspicious mail and packages? Yes No
Violence Intervention program? Yes No
Drug/Alcohol awareness program? Yes No
Any premises or jobsite security provided? Yes No If yes, please describe: _____

CATASTROPHE EXPOSURE INFORMATION

Identify all annual or regular business meetings, trade shows, conventions, training or other company events where 10 or more employees attend:

Type of Meeting, Location and Date	City	State	Zip Code	Number of Employees Attending

Does Insured have employees (10 or more) regularly working in close proximity (within 2 miles) to any of the following types of buildings or facilities (check all that apply):

<input type="checkbox"/> Government or Military Installations	<input type="checkbox"/> Specialized Industries supporting the Military	<input type="checkbox"/> Manufacturers of environmentally sensitive products
<input type="checkbox"/> Large Financial Institutions including national and regional stock exchanges	<input type="checkbox"/> Major Bridges, Tunnels, or Dams	<input type="checkbox"/> Transportation Hubs-Railroads, Airports, or Shipping
<input type="checkbox"/> Communication Centers: Major Network Radio and Television and Voice and Data Centers	<input type="checkbox"/> Utilities or Power Generation Plants	<input type="checkbox"/> Bulk Storage facilities (tank farms)
<input type="checkbox"/> Sport Stadiums/Arenas and Theme Parks	<input type="checkbox"/> Large Colleges, Universities or Schools	<input type="checkbox"/> Large Shopping Malls
<input type="checkbox"/> Historic/Symbolic buildings monuments, or parks	<input type="checkbox"/> Explosives manufacturing, distribution or storage	<input type="checkbox"/> Chemical manufacturing including pesticide, herbicide, or insecticide

Please provide the Insured’s street addresses where 10 or more employees work within close proximity to any of the above identified buildings or facilities: _____

LOCATION/EXPOSURE INFORMATION – Attach extra copies of the following tables, if needed to identify all of the Insured’s locations and employee exposures

LOCATIONS (Actual street locations where operations are conducted, not mailing addresses)

Location #	Street, City, State, Zip Code
01	
02	
03	
04	
05	
06	
07	
08	
09	
10	
11	
12	
13	
14	
15	

