



## WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION

Named Insured: \_\_\_\_\_

Insured Email Address\*(Required to Rate): \_\_\_\_\_

### Description of Operations

**Select Program:**

Crane & Rigging       Specialized Transportation       Concrete Pumping       Equipment Dealers/Rental

Years in Business: \_\_\_\_\_

Complete Description of Operations: \_\_\_\_\_

Individual       Partnership       Corporation       Limited Corporation       Joint Venture

Other : \_\_\_\_\_

Current X Mod: \_\_\_\_\_ Anniversary Date: \_\_\_\_\_

Any Acquisitions or Ownership changes in the past two years?      Yes       No

Ownership: Active in Management?      Yes       No

Number of Full Time Employees: \_\_\_\_\_

Number of Part Time Employees: \_\_\_\_\_ Number of Seasonal Employees: \_\_\_\_\_

Average number of field operations employees: \_\_\_\_\_

Number of W2's filed for the latest reporting year: \_\_\_\_\_

Number of Employees are:      \_\_\_ Increasing      \_\_\_ Decreasing      \_\_\_ Stable

Union Affiliation:      # Non-Union:      # Union:

Mainstream Employees wage per hour:      Starting: \$ \_\_\_\_\_      Average: \$ \_\_\_\_\_

Hours of Operation: (#days, hours open) \_\_\_\_\_      Number of Shifts: \_\_\_\_\_

Radius of Operation: \_\_\_\_\_

Transportation Provided?      Yes       No       Frequency: \_\_\_\_\_      Mode: \_\_\_\_\_

### Benefits and Hiring Practices

Group Medical Provided?      Yes \_\_\_\_\_      No \_\_\_\_\_

Clinic: \_\_\_\_\_ Physician: \_\_\_\_\_

Waiting Period for Benefits: \_\_\_\_\_      Percent Paid by Employer: \_\_\_\_\_

# of Employees Participating:      Dental: \_\_\_\_\_      Vacation: \_\_\_\_\_      Paid Sick Leave: \_\_\_\_\_

Employment Application	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
References Checked	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pre-Employment Physicals	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pre-Placement Audiogram	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Drug Screening Program – Pre-Placement	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No



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Drug Screening Program – Post Accident	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Written Disciplinary Procedure in Place	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Drug/Alcohol Rehab Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Employee Assistance Programs	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Return to Work Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Does Insured Offer Modified Work Schedule	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any Interchange of Labor	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Certificates of Insurance Obtained	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any Sports or other Recreational Activities Allowed on Premises	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Name/Title of Person Conducting Interviews:				
How are Qualifications of Employees Verified?				

### Safety Practices

Name and Title of Person Responsible for Safety: \_\_\_\_\_

Name and Title of Primary Claims Contact: \_\_\_\_\_

Claims/Losses Incident Rate: \_\_\_\_\_ Severity Rate: \_\_\_\_\_

Written Safety Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Safety Program Accountability	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Back Injury Prevention Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Code of Safe Practices (Written & Enforced Company Safety Rules)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Employee/Management Safety Incentive Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Fall Protection Program, Height Exposure _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Fleet Safety Program: # Vehicles _____, MVR's _____%, Company Used _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Maintain Your Own Vehicles	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Haz Com Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Lockout/Tagout Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Trenching Safety Program, Maximum Depth _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Management Incent Investigation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Mobile equipment Training Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
• Personal Protective Equipment Program	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
New Employee Orientation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Employee Safety Training (Documented)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Substance Abuse Policy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hazardous Conditions Abatement Documentation	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Workplace Safety Inspections	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Smoking Allowed on job Sites/Premises	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
OCIP (Owner/Contractor Insurance Programs)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Delivery Exposure:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Delivery Frequency:	Delivery Radius: _____			

### Contractor's Operations

Commercial \_\_\_\_\_%    Industrial \_\_\_\_\_%    Residential \_\_\_\_\_%    Service/Repair \_\_\_\_\_%



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New \_\_\_\_%                      Remodel \_\_\_\_%                      Demolition \_\_\_\_%                      SubContract \_\_\_\_%

Do employees work more than 3 stories above ground being raised by lifts or hoisting devices?:  Yes  No

If yes, how high?: \_\_\_\_\_

Percentage of operations that is sub-out trucking: \_\_\_\_\_%

Does insured utilize owner operations?:  Yes  No

If yes, what percentage of operation: \_\_\_\_\_%

Percentage of operations exceeds 200 mile radius: \_\_\_\_\_

What is the insured hauling and what percentage is:

Coil \_\_\_\_%      Rolled or Steel Beams \_\_\_\_%      General Freight \_\_\_\_%      Hazardous Material \_\_\_\_%

Percentage of payroll from Stand Alone Rigging: \_\_\_\_\_%

Out of State Travel – Description of Operations: \_\_\_\_\_

# Employees involved in Out of State Travel: \_\_\_\_\_ Location: \_\_\_\_\_

Frequency of Travel: \_\_\_\_\_ Duration of Travel: \_\_\_\_\_ Days/ \_\_\_\_\_ Months

### USL&H

Is "if any" contractual USL&H needed?		Yes		No
Is any work done on a ship, shipyard or marina?				
If yes, circle <u>OVER</u> , <u>NEAR</u> , or <u>ADJACENT TO</u> navigable waterway		Yes		No
Is any work done on a barge?				
If yes, circle <u>OVER</u> , <u>NEAR</u> , or <u>ADJACENT TO</u> navigable waterway		Yes		No
Is any work done on a navigable waterway? (waterway with the capacity to provide access directly or indirectly to interstate or international waters)				
If yes, circle <u>OVER</u> , <u>NEAR</u> , or <u>ADJACENT TO</u> navigable waterway		Yes		No
Is any work done on any bridge?				
If yes, circle <u>OVER</u> , <u>NEAR</u> , or <u>ADJACENT TO</u> navigable waterway		Yes		No
Is any work done on port authority property?				
If yes, circle <u>OVER</u> , <u>NEAR</u> , or <u>ADJACENT TO</u> navigable waterway		Yes		No
Is the USL&H exposure state specific? List states:		Yes		No
Confirm understanding of USL&H provided is incidental only		Yes		No
The Agent and the Insured understand that any changes in operations pertaining to USL&H must be reported within thirty (30) days		Yes		No
Will the applicant own, lease, charter or borrow any watercraft on a navigable waterway?		Yes		No
Will the applicant employ anyone as a Master or Member of the crew of any watercraft on a navigable waterway?		Yes		No
Will the applicant employ anyone to perform any work on or from a watercraft under navigation?		Yes		No
Will the applicant contract any work to be performed on or from a watercraft under navigation without reviewing proof of maritime coverages for the contractor's workers?		Yes		No



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### ATTENTION

1. THE APPLICANT WARRANTS THAT THE ABOVE STATEMENTS AND PARTICULARS, TOGETHER WITH ANY ATTACHED OR APPENDED DOCUMENTS OR MATERIALS ("THIS APPLICATION"), ARE TRUE AND COMPLETE AND DO NOT MISREPRESENT, MISSTATE OR OMIT ANY MATERIAL FACTS.
2. THE APPLICANT UNDERSTANDS THAT THE COMPANY RELIED UPON THE INFORMATION CONTAINED WITHIN THIS APPLICATION TO DETERMINE ACCEPTABILITY, RATES AND COVERAGE.
3. THE APPLICANT UNDERSTANDS THAT ANY MISREPRESENTATION OR OMISSION SHALL CONSTITUTE GROUNDS FOR RESCISSION OF COVERAGE AND DENIAL OF CLAIMS, OR, AT THE OPTION OF THE COMPANY, THE ASSESSMENT OF ADDITIONAL PREMIUM CHARGES. THE APPLICANT REPRESENTS AND WARRANTS TO THE COMPANY THAT, IF A POLICY IS ISSUED TO THE APPLICANT, THE APPLICANT WILL COOPERATE WITH THE COMPANY IN CONNECTION WITH ANY INSPECTION, PREMIUM AUDIT AND IN ALL OTHER RESPECTS AS REQUIRED UNDER THE POLICY.
4. IF THE APPLICANT BECOMES AWARE THAT ANY RESPONSE ON THIS APPLICATION IS INACCURATE AS A RESULT OF INFORMATION OR CHANGE OF CIRCUMSTANCES BEFORE A POLICY IS ISSUED, THE APPLICANT MUST INFORM THE COMPANY OF SUCH CHANGE, IN WRITING, AND ANY POLICY ISSUED BEFORE SUCH NOTIFICATION IS SUBJECT TO IMMEDIATE CANCELLATION.

("APPLICANT", "YOU", "YOUR" AND SIMILAR WORDS REFER TO THE PROSPECTIVE INSURED)

THE TERMS, CONDITIONS AND EXCLUSIONS CONTAINED IN POLICIES ISSUED BY THE COMPANY VARY SIGNIFICANTLY FROM THOSE CONTAINED IN MANY OTHER LIABILITY INSURANCE POLICIES. THE POLICY FORM ISSUED BY THE COMPANY PROVIDES COVERAGE THAT MAY BE MORE LIMITED THAN THAT AVAILABLE UNDER THE "ISO" INSURANCE POLICY OR SIMILAR TYPES OF POLICIES. YOU SHOULD CAREFULLY REVIEW THE ENTIRE POLICY WITH YOUR AGENT, LEGAL COUNSEL OR OTHER INSURANCE PROFESSIONAL TO MAKE SURE THAT YOU UNDERSTAND THE COVERAGE IT PROVIDES, AND YOUR RIGHTS AND OBLIGATIONS UNDER THE POLICY.

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTE: Fraud warnings contained in ACORD Form 63 – Fraud Statement must be attached to this application

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title (Officer, Manager, Partner, Owner)

\_\_\_\_\_  
Signature of Broker

\_\_\_\_\_  
Date