TREAN CORPORATION

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	☐ Yes	☐ No
References Checked	☐ Yes	☐ No
Pre-Employment Physicals	☐ Yes	☐ No
Pre-Placement Audiogram	☐ Yes	☐ No
Drug Screening Program – Pre-Placement	☐ Yes	☐ No

Drug Screening Program – Post Accident	☐ Yes	☐ No
Written Disciplinary Procedure in Place	☐ Yes	☐ No
Drug/Alcohol Rehab Program	☐ Yes	☐ No
Employee Assistance Programs	☐ Yes	☐ No
Return to Work Program	☐ Yes	☐ No
Does Insured Offer Modified Work Schedule	☐ Yes	☐ No
Any Interchange of Labor	☐ Yes	☐ No
Certificates of Insurance Obtained	☐ Yes	☐ No
Any Sports or other Recreational Activities Allowed on Premises	☐ Yes	☐ 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	☐ Yes	☐ No
Safety Program Accountability	☐ Yes	☐ No
• Back Injury Prevention Program	☐ Yes	☐ No
• Code of Safe Practices (Written & Enforced Company Safety Rules)	☐ Yes	☐ No
• Employee/Management Safety Incentive Program	☐ Yes	☐ No
• Fall Protection Program, Height Exposure _____	☐ Yes	☐ No
• Fleet Safety Program: # Vehicles _____, MVR's _____%, Company Used _____	☐ Yes	☐ No
• Maintain Your Own Vehicles	☐ Yes	☐ No
• Haz Com Program	☐ Yes	☐ No
• Lockout/Tagout Program	☐ Yes	☐ No
• Trenching Safety Program, Maximum Depth _____	☐ Yes	☐ No
• Management Incent Investigation	☐ Yes	☐ No
• Mobile equipment Training Program	☐ Yes	☐ No
• Personal Protective Equipment Program	☐ Yes	☐ No
New Employee Orientation	☐ Yes	☐ No
Employee Safety Training (Documented)	☐ Yes	☐ No
Substance Abuse Policy	☐ Yes	☐ No
Hazardous Conditions Abatement Documentation	☐ Yes	☐ No
Workplace Safety Inspections	☐ Yes	☐ No
Smoking Allowed on job Sites/Premises	☐ Yes	☐ No
OCIP (Owner/Contractor Insurance Programs)	☐ Yes	☐ No
Delivery Exposure:	☐ Yes	☐ 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

Signatures

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.

Signature of Applicant **Date**

Title (Officer, Manager, Partner, Owner)

Signature of Broker **Date**

ATTENTION