TREAN CORPORATION

Funeral Home Supplemental

Named Insured: _____

Website: _____

Detailed Description of Operations: _____

Hours of Operation: _____

Driving or Delivery Mileage **%** of Each:	☐ <50	☐ 50-100	☐ 100+	☐ N/A
Group Transportation:	☐ No	☐ Yes	**If yes, # of Employees:**	☐ #
Are Vehicles Company Owned:	☐ No	☐ Yes	☐ N/A	
Vehicle Maintenance Program:	☐ In-House	☐ Outside Vendor	☐ No	
Distracted Driving policy in place:	☐ No	☐ Yes	☐ N/A	
Drivers Training:	☐ No	☐ Yes	☐ N/A	
Overnight Travel by Employees:	☐ No	☐ Yes	**If yes, frequency:**	
Employees (# of Each):	☐ Full Time	☐ Part Time	☐ Seasonal	☐ Volunteers
How are Employees Paid:	☐ Hourly	☐ Commission	☐ Salary	**Other:**
Benefits Offered (check all that apply):	☐ Paid Sick Time	☐ Paid Vacation	☐ 401k	☐ Retirement
Group Health Coverage:	☐ Yes	☐ No	**If yes, what % of payroll**	☐ %
Pre Hire (check all that apply):	☐ Written Application	☐ Reference Checks	☐ Physicals	
	☐ Pre-Hire Drug Testing	☐ Random Drug Testing	☐ Post Accident Drug Testing	
	☐ Pre-Hire MVR Checks	☐ Annual MVR Checks	☐ Criminal Background Checks	
	Other, please list:			
Return-To-Work/Light Duty Available:	☐ Formal/Written	☐ Informal/Verbal	☐ None	
Employee Average Annual Turnover:	☐ %			
Subcontractors Used:	☐ No	☐ Yes	**If yes, what % of payroll**	☐ %
Are COIs Obtained for Subs:	☐ Yes	☐ No	☐ N/A	
Day Laborers or Employee Leasing:	☐ Yes	☐ No		
Safety Program in Place:	☐ Formal/Written	☐ Informal/Verbal	☐ None	
Safety Training:	☐ Yes	☐ No	☐ Documented	☐ Verbal
Safety Meetings:	☐ Yes	☐ No		
If yes, frequency:	☐ Weekly	☐ Monthly	☐ Quarterly	☐ Annually
Lifting Exposures:	☐ <25lbs	☐ 25-40lbs	☐ 40+lbs	☐ N/A
Machinery Guarded & Maintained:	☐ Yes	☐ No	☐ N/A	
Lockout/Tagout:	☐ Yes	☐ No	☐ N/A	
Forklifts Used:	☐ No	☐ Yes	☐ **Check Box if Operators Are Annually Certified**	
Maximum Depth in Feet:	☐ 0-3 Feet	☐ 4-7 Feet	☐ 8 Feet and Below	☐ N/A
Maximum Height in Feet:	☐ 0-6 Feet	☐ 7-15 Feet	☐ 15 Feet and Above	☐ N/A
If heights, what is used:	☐ Scissor Lift	☐ Scaffolding	☐ Bucket Truck	☐ Ladder
	Other, please describe:			
List all Personal Protective Equipment:	☐ Gloves	☐ Back Belts	☐ Protective Clothing	☐ Ear Plugs
	☐ Goggles	☐ Non-Slip Shoes	☐ Steel Toed Boots	☐ Masks
	☐ Hard Hats	**Other, please list:**		
Blood/Other infectious materials handling program in place:	☐ Yes	☐ No		
Insured has home on the premises?	☐ Yes	☐ No		
Average Number of Funerals handled:	☐ Weekly	☐ Annually		
Drivers familiar with local and state traffic ordinances concerning funeral processions?	☐ Yes	☐ No		
Provide Transportation Details:				
Details regarding the levels of training, licensing and experience for the embalmers:				
Proper preparation room ventilation in place:	☐ Yes	☐ No		
Training regarding exposure to formaldehyde concentrations of 0.1 ppm or greater:	☐ Annually	☐ Pre-Hire		
Exposure to 0.75 parts formaldehyde ppm longer than an eight-hour time period:	☐ Yes	☐ No		
Showers/Eyewash Stations	☐ Yes	☐ No		
All Mixtures and Solutions Labeled	☐ Yes	☐ No		
Does insured offer "Green" Funerals:	☐ Yes	☐ No		
Types of materials-handling devices used to move bodies and caskets:	☐ Multi Level Mortuary Stretchers		☐ Hydraulic Manual Scissor Lifts	
	☐ Mortuary Trolleys		☐ Automated Scissor Lifts	
	☐ Casket trolleys		☐ Embalming Table	
	☐ Mortuary Tables With Wheels		☐ Vehicle Loading Equipment	
Other Material Handling Devices:				
Cremation chamber on premises:	☐ Yes	☐ No		
If Yes, Types of Creamation:	☐ Alkaline Hydrolysis	☐ Flame-Based	**Other, please list:**	
Compliance with applicable local, state, and federal regulations?	☐ Yes	☐ No		
NFDA for waste disposal methods followed	☐ Yes	☐ No	**Other, please list:**	

Provide Methods Used:					
Funeral Home Type:	☐	Part of a Chain	☐	Private Business	
Extra security measures taken during high profile funerals:	☐	No	☐	Check Box if Insured's EE's	☐ Check Box if Outside Security Firm & that COI's are Obtained
List Association Affiliations:					

Affirmation

The undersigned acknowledges and understands the information provided herein will be used to evaluate the applicant and a decision as to whether the applied to insurance company will offer workers' compensation insurance will be made, in part, based on the information provided. Signature below indicates the information provided is true and correct. This Supplemental Application must be signed by a principle, owner or partner of the entity applying for insurance.

Owner/Officer Signature: _____ **Date:** _____