General 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,% paid by employer:**	☐ %
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, Documented	☐ Yes, Verbal	☐ None	
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:			
Provide details regarding what the insured has implemented to keep employees safe in response to COVID19:				
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:**		

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:** ______________________