Manufacturing 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 Insured:**	%
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**	
Weight of final product:	Less than 5 lbs	5-25 lbs	26-50 lbs	Over 50 lbs
Emergency Plan in Place in Case of Fire:				
Please Describe Plan in Detail:				
Provide % of Labor that is Manual vs Automated:	Manual	Automated		
Provide % of MANUAL Operation Using the Following:	% CNC	% Drilling	% Jig Boring	% Sandblasting
	% Die Casting	% Milling	% Stamping	% Punch Press
	% Saws	% Lathes	% Cutters	% Press Brakes
	% Power Presses	% Boring	% Planing	% Welding
	% Grinders	**Other, please describe:**		
Equipment/Machinery Maintenance:	Handled by Insured	Handled by Contractor	**Other, Please Describe:**	
Installation Services Provided by Insured:	No	Yes	**If Yes, % of Operation:**	%
	Provide Installation Process Details:			
Off Site Services Provided by Insured:	No	Yes	**If Yes, % of Operation:**	%
	Provide Installation Process Details:			
Age Of Machinery:	Less than 2 Years	2-5 Years	5-10 Years	10+ Years
Is the Building Property Ventilated:	No	Yes		
Is there a Dust Collection System in Place:	No	Yes	N/A	
What type(s) of raw materials are used:				
What is the End Product:				
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:** ____________________