Republic Indemnity®

ATTORNEY SUPPLEMENTAL
WORKERS' COMPENSATION APPLICATION

Application/Policy #: _____ Effective Date: _____

Insured Name: _____ Federal ID #: _____
Website: _____ Email: _____
Agency Name:_____ Contact: _____

Payroll Data: Provide historical payroll data by class (for current and prior 4 years) or submit final audit invoices if available. **Applicable only to policy years not insured by Republic Indemnity.**

	Class		Class		Class		Class		Class	
Current Year										
1st Year Prior										
2nd Year Prior										
3rd Year Prior										
4th Year Prior										

Loss Experience

If the insured has not been insured by Republic Indemnity for the latest 3-year term, please attach **currently valued loss runs** for any of those three years insured elsewhere and **most current experience modification worksheet** if available.

Operational Information

1. List the most prominent areas of practice: _____
2. Does more than 10% of the practice involve any of the following?
   - Bad Faith Yes ○ No ○
   - Criminal Law Yes ○ No ○
   - Family Law Yes ○ No ○
   - Personal Injury Yes ○ No ○
   - Workers' Compensation Yes ○ No ○
3. Any Investigators, process servers and/or couriers on staff? Yes ○ No ○
   - If these services are contracted are certificates of W/C obtained?
   - Provide details_____
   - Provide Percentage Breakdown of: Phone Investigators _____% Outside Investigators _____%

General Information

1. Current number of permanent employees: _____
   Number of temporary/seasonal employees: _____
   Number of W2's filed for latest reporting year: _____
2. **How many independent contractors are used?** _____
   How many 1099 forms are issued to individuals? _____
   How many 1099 forms are issued to companies/organizations? _____
   If there are independent contractors, what kind of work do they perform? _____

Are independent contractors covered under a statutory Workers' Compensation Insurance policy and do they provide Certificates of Insurance? Yes ○ No ○

3. Number of employees: Increasing _____ Decreasing _____ Stable _____
4. Number of part-time employees: _____ Number of full-time employees: _____
5. Mean wage: For mainstream employees in production operations or services offered $ _____/hr.
   For administrative staff (e.g. clerical, sales) $ _____/hr.
6. Number of employees working from home: _____
   Average number of days per week working from home: _____
7. Group Medical: Yes ○ No ○ Name of Group Medical Provider: _____
   % of employees participating: _____ % of employer contribution: _____
   Paid Vacation: Yes ○ No ○ Paid Sick Leave: Yes ○ No ○ 401K or Pension: Yes ○ No ○
8. Safety Program: Yes ○ No ○
   Safety meetings held for all employees: Yes ○ No ○
   Personal protective safety equipment provided: Yes ○ No ○
   Accident investigation program in place: Yes ○ No ○
9. Pre-employment physical: Yes ○ No ○
10. Drug Screening Program/Random Drug Testing: Yes ○ No ○
11. Does insured offer modified work: Yes ○ No ○
    If yes, provide details: _____
12. Percent of Off Premise Operations: _____%
13. Vehicle Exposure: Radius of Operations: _____
    Number of Commercial Vehicles: _____ Number of Private Passenger Vehicles: _____
    Details of use, including specifics regarding delivery exposure and towing/roadside assistance, if applicable:
    _____
    Number of employees driving on a regular basis (we define regular as 10% or more of employees' time): _____
    Frequency of off-premises activity: Daily ○ Less than Daily ○
    What are the average and maximum number of covered employees that travel together in the same vehicle?
    _____
    How often do the maximum number of covered employees travel together in the same vehicle? _____
    MVR's checked: Yes ○ No ○ If yes, please provide details as to procedures in place: _____
    _____
    Is there a disciplinary/termination rule in place based on driving record? Yes ○ No ○ If yes, describe how this is implemented: _____
14. Is there any out-of-state travel? Yes ○ No ○ If yes, who travels? _____
    Where do they travel? _____ How long do they travel for? _____
15. Does applicant own, operate, or lease aircraft? Yes ○ No ○
    If yes, provide details: _____
16. Are any of the insured's operations located within a Federal or State government owned building that is over 35% occupied by governmental offices or National Landmarks? Yes ○ No ○
    If yes, provide details: _____

Location(s) – Please complete for all locations of business operations:

	Number of Employees assigned to the location (including those who work off premises)		# of Shifts	Maximum number of employees on the premises at one time	# of Stories and Floor # occupied by this business		Building Construction Type *(see below)
	Full-time	Part-time			# Stories	Floor #	
Location (1)							
Street							
City, State, Zip							
Location (2)							
Street							
City, State, Zip							
Location (3)							
Street							
City, State, Zip							

If there are more than 3 locations, please continue on a separate sheet.

*Types of Building Construction that closely matches the description of the building that the insured occupies.

Wood Frame, including masonry veneer	Tilt-up concrete
Unreinforced masonry	Reinforced concrete
Reinforced masonry	Light gauge steel frame
Mobile home	Protected structural steel frame

Policy Specifications

Non-Participating Plan ○ Participating ○

Program: Yes ○ No ○ If yes, Program Name: _____

Commission: _____% Direct Bill ○ Agency Bill ○

Producer Authorized Signature: _____ Date: _____

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.