Republic Indemnity

ATTORNEYS SUPPLEMENTAL
UNDERWRITING QUESTIONNAIRE **Application/Policy#_____**

Insured Name: _____ Federal ID #: _____
Effective Date: _____ Web Address: _____ Insurance Contact Email :_____
Agency:_____ 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: (includes all employees, sales & clerical)	8820		
YEAR			
Current			
1st Prior Yr			
2nd Prior Yr			
3rd Prior Yr			
4th Prior Yr			

Loss Experience

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

Operational Information

1. Type of Practice, provide % breakdown: _____ _____ _____
   - Any Workers' Compensation Yes ○ No ○
   - Any Personal Injury Yes ○ No ○
   - Any Criminal Yes ○ No ○
   - Any Family Law Yes ○ No ○
   - *If yes, provide explanation* _____
2. Any Investigators, process servers and/or couriers on staff? Yes ○ No ○
   - If these services are contracted are certificates of W/C obtained? Yes ○ No ○
   - Provide details_____
   - Provide % Breakdown of: Phone Investigators _____ Outside Investigators _____
3. Ratio of support staff vs. attorneys: # of Attorneys (including Principals) _____ # of Support Staff _____
4. Any involvement in athletic activities? Yes ○ No ○
   - *If yes, provide details*_____
5. Does the firm represent clients in actions against insurance companies, such as bad faith or coverage litigation? Yes ○ No ○
   - *If yes, provide details:* _____
6. Does the firm ever sue employers on behalf of workers? Yes ○ No ○
   - *If yes, provide details*_____
7. Does the firm handle applicant or defense workers' compensation cases? Yes ○ No ○
   - *If yes, provide details*_____

General Information

1. Current number of permanent employees_____
   - Number of temporary/seasonal employees_____
   - Number of W2's filed for latest reporting year_____
2. Number of employees: Increasing _____ Decreasing _____ Stable _____
3. Number of part-time employees _____ Number of full-time employees_____
4. Mean wage: For mainstream employees in production operations or services offered $_____/hr.
   For administrative staff (e.g. clerical, sales) $_____/hr.
5. Group Medical provided: 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 ○
6. 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 ○
7. Pre-employment physical: Yes ○ No ○
8. Drug Screening Program/Random Drug Testing Yes ○ No ○
9. Does insured offer modified work?: Yes ○ No ○
   - *If yes, provide details*_____
10. Percent of Off Premises Operations:_____%

11. Vehicle Exposure: Radius of Operations _____
#Vehicles_____(comm'l) _____ (private passenger)
Details of use, including specifics as to delivery exposures, if applicable _____
_____

Number of employees regularly driving: *_____
*We define regular as over 10% of all employees time in the aggregate being spent off-premises.
Frequency of all 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*
_____

12. Is there any out-of-state travel? Yes ○ No ○ If yes, who travels? _____
Where do they travel? _____ How long do they travel for? _____
13. Does applicant own, operate or lease aircraft? Yes ○ No ○ *If yes, provide details* _____
_____

14. 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*_____

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

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

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

*Types of Building Construction that closely matches the description of building that 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

Commission %_____ Participating _____ Direct Bill _____ Program_____ Agency Bill _____ Program Name: _____

Producer Authorized Signature _____ Date_____