Republic Indemnity

CABINET SHOP
WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION

Application/Policy#_____

Insured Name: _____ Federal ID #: _____
Effective Date: _____Website:_____ 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:				
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 attach **currently valued loss runs** for any of those three years insured elsewhere **and most current experience modification worksheet** if available.

Operational Information

1. What kinds of items are manufactured?
   _____
2. Is this a custom shop or production shop? _____
3. What is the average and maximum weight manually handled? Average _____ Maximum _____
4. Describe material handling controls in place (e.g. forklifts, hoists, carts, etc.)
   _____
5. Type of machinery used in production (select all that apply and indicate number):
   - ☐ CNC (computer-numeric controlled) _____
   - ☐ Table Saws _____
   - ☐ Band Saws _____
   - ☐ Planers Drill _____
   - ☐ Presses _____
   - ☐ Lathes _____
   - ☐ Other (provide details) _____
6. Is all machinery guarded? Yes ○ No ○
7. Are any of the following done? If yes, provide number of employees involved and details.
   Painting Yes ○ No ○ # of employees:_____ Is there an approved paint booth?_____
   Assembly Yes ○ No ○ # of employees:_____
8. Does insured have a formal safety plan? Yes ○ No ○
9. PPE (Personal Protective Equipment) provided or required? Yes ○ No ○ If yes, provide details _____
   _____

General Information

1. Current number of permanent employees _____ Seasonal Employees _____
   Number of temporary and/or leased employees _____
   Does the insured utilize the services of Temporary Staffing Agencies or Labor Contractors? Yes ○ No ○
   If yes, do they require contract language that specifies the Agency/Contractor provide Workers' Comp? Yes ○ No ○
   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. Union ○ Non-Union ○ % of employees participating_____
6. **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○
7. Group Medical provided: Yes ○ No ○ Name of Group Health 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. Hiring Practices
   Application: Yes ○ No ○
   Check References: Yes ○ No ○
10. Pre-employment physical: Yes ○ No ○
    Drug Screening Program/Random Drug Testing: Yes ○ No ○
11. Does insured offer modified work?: Yes ○ No ○
    *If yes, provide details*_____
12. Loss Control Incentive Program: Yes ○ No ○
13. Percent of Off Premises Operations: _____%
    Delivery: Yes ○ No ○ Number of Employees Involved: _____
    Number of Vehicles Utilized: _____ Radius of Operations _____
    Installation: Yes ○ No ○ Number of Employees Involved: _____
    Number of Vehicles Utilized: _____ Radius of Operations _____
    Group Transportation Provided: Yes ○ No ○
    Details of use, *include specifics as to delivery exposures*_____
    _____
    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. Does applicant own, operate or lease aircraft? Yes ○ No ○ *If yes, provide details* _____
    _____
15. Hours of operation _____
16. Did producer pre-inspect the premises: Yes ○ No ○
17. 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 _____

Locations(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

Producer Authorized Signature _____Date_____