

**FINANCIAL INSTITUTION
WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION**

Application/Policy# _____

Insured Name: _____ Federal ID #: _____
Effective Date: _____ Website: _____ Insurance Email : _____
Agency: _____ Contact: _____

Payroll Data – Provide historical payroll data by class (for current and prior 4 years), or submit final audit invoices if available. This is applicable only to policy years not insured by Republic Indemnity.

<u>Class:</u>	8855	_____	_____
<u>YEAR</u>			
<u>Current</u>	_____	_____	_____
<u>1st Prior Yr</u>	_____	_____	_____
<u>2nd Prior Yr</u>	_____	_____	_____
<u>3rd Prior Yr</u>	_____	_____	_____
<u>4th Prior Yr</u>	_____	_____	_____

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

- Will security guards be utilized? Yes No # Armed: _____ # Unarmed: _____
If yes, will they be: Bank employees? Yes No Contractors? Yes No
If contracted, is evidence of Workers' Compensation coverage maintained on file? Yes No
Please provide name of Insurance Company: _____
(If written, evidence of coverage will need to be included with the bind order.)
- Do bank employees conduct appraisals? Yes No Will this be contracted? Yes No
If contracted, is evidence of Workers' Compensation coverage maintained on file? Yes No
Please provide the name of company(ies) providing this service: _____
- Does the bank conduct and/or provide for others any:
Printing? Yes No
Warehousing? Yes No
- Do any employees work predominately at home? Yes No If yes, number of employees: _____

General Information

- Number of years in business: _____
- Hours of Operation: _____
- Current number of permanent employees: Full-Time _____ Part-Time _____
Number of temporary/seasonal employees _____
Number of W2's filed for latest reporting year _____
- Number of employees: Increasing _____ Decreasing _____ Stable _____
- Number of part time employees _____ Number of full time employees _____
Average hourly wage: _____
- Group Medical provided: Yes No Name of Group Medical Provider: _____
% of employees participating _____ % of employer contribution _____
Paid Vacation: Yes No Sick Leave: Yes No 401K or Pension: Yes No
- Pre-employment physical: Yes No
- Drug Screening Program/Random Drug Testing: Yes No
- Does the insured offer modified work? Yes No
If yes, provide details _____

- 10. Safety Program: Yes No
- Safety Meetings: Yes No
- Personal protective safety equipment provided: Yes No
- Accident investigation program in place: Yes No

- 11. Hiring Practices
 - Application: Yes No
 - Check References: Yes No

12. Percent of Off Premises Operations: _____%

13. 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 number of covered employees travel together in the same vehicle? _____

Is there a disciplinary/termination rule in place based on driving record? Yes No

If yes, describe how this is implemented _____

MVR's checked: Yes No *If yes, please provide details as to procedures in place* _____

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 an 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:

	# 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)
	<u>Full-time</u>	<u>Part-time</u>				
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
- Unreinforced masonry
- Reinforced masonry
- Mobile home
- Tilt-up concrete
- Reinforced concrete
- Light gauge steel frame
- Protected structural steel frame

Producer Authorized Signature _____ Date _____