



FINANCIAL INSTITUTION 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.

Table with 10 columns: Year (Current Year, 1st Year Prior, 2nd Year Prior, 3rd Year Prior, 4th Year Prior) and 5 Class columns.

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. 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.)
2. 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:
3. Does the bank conduct and/or provide for others any: Printing? Yes No Warehousing? Yes No
4. Do any employees work predominately at home? Yes No If yes, number of employees: \_\_\_\_\_

General Information

- 1. Number of years in business: \_\_\_\_\_
2. Hours of Operation: \_\_\_\_\_
3. Current number of permanent employees: Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_
Number of temporary/seasonal employees: \_\_\_\_\_
Number of W2's filed for latest reporting year: \_\_\_\_\_



4. 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
5. Number of employees: Increasing \_\_\_\_\_ Decreasing \_\_\_\_\_ Stable \_\_\_\_\_
6. Number of Full-Time employees: \_\_\_\_\_ Number of Part-Time employees: \_\_\_\_\_  
Average hourly wage: \_\_\_\_\_
7. Number of employees working from home: \_\_\_\_\_  
Average number of days per week working from home: \_\_\_\_\_
8. 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
9. 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
10. Hiring Practices  
Application: Yes No  
Check References: Yes No
11. Pre-employment physical: Yes No
12. Drug Screening Program/Random Drug Testing: Yes No
13. Does insured offer modified work: Yes No  
If yes, provide details: \_\_\_\_\_
14. Percent of Off Premise Operations: \_\_\_\_\_%
15. 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: \_\_\_\_\_
16. Is there any out-of-state travel? Yes No If yes, who travels? \_\_\_\_\_  
Where do they travel? \_\_\_\_\_ How long do they travel for? \_\_\_\_\_
17. Does applicant own, operate or lease aircraft? Yes No  
If yes, provide details: \_\_\_\_\_
18. 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 #	

<b>Location (1)</b>						
Street						
City, State, Zip						

<b>Location (2)</b>						
Street						
City, State, Zip						

<b>Location (3)</b>						
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: \_\_\_\_\_