



**MACHINE SHOP 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
<b>Current Year</b>									
<b>1<sup>st</sup> Year Prior</b>									
<b>2<sup>nd</sup> Year Prior</b>									
<b>3<sup>rd</sup> Year Prior</b>									
<b>4<sup>th</sup> Year Prior</b>									

**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**

- What kind of items are machined? \_\_\_\_\_
- What is the average and maximum any one part would weigh? Average \_\_\_\_\_ Maximum \_\_\_\_\_
- Describe material handling controls in place (e.g. forklifts, hoists, carts, etc.) \_\_\_\_\_
- What percentage of employees have the following skill levels? High \_\_\_\_\_ Medium \_\_\_\_\_ Low \_\_\_\_\_
- Is employee training provided? Yes No
- Is the machining considered high tolerance? Yes No High precision? Yes No
- Total number of machines used in production \_\_\_\_\_
- Type of machinery used in production (select all that apply and indicate number):
 

	<u>Number</u>
CNC (computer-numeric controlled) Conventional	_____
Metal Forming	_____
Power press	_____
Grinding/Buffering/Polishing	_____
Other _____	_____

 Provide details: \_\_\_\_\_
- Is all machinery guarded? Yes No
- Are any of the following done? If yes, provide the number of employees involved and the details for each one.
 

Welding	#Emp: _____	Details: _____
Sandblasting	#Emp: _____	Details: _____
Heat Treating	#Emp: _____	Details: _____
Plating	#Emp: _____	Details: _____
Anodizing	#Emp: _____	Details: _____



Painting #Emp: \_\_\_\_\_ Details: \_\_\_\_\_  
 Siding #Emp: \_\_\_\_\_ Details: \_\_\_\_\_

11. Does insured have a formal safety plan? Yes No  
 12. Any exotic metals used (e.g. titanium, magnesium, beryllium, etc.)? Yes No  
 If yes, provide details \_\_\_\_\_

**General Information**

1. Current number of permanent employees: Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_  
 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. Mean wage: For mainstream employees in production operations or services offered \$ \_\_\_\_\_/hr.  
 For administrative staff (e.g. clerical, sales) \$ \_\_\_\_\_/hr.
5. Union Non-Union Percentage of employees participating \_\_\_\_\_%
6. Group Medical: Yes No Name of Group Medical Provider: \_\_\_\_\_  
 Percentage of employees participating: \_\_\_\_\_% Percentage of employer contribution: \_\_\_\_\_%  
 Paid Vacation: Yes No Paid Sick Leave: Yes No 401K or Pension: Yes No
7. 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
8. Hiring Practices: Yes No  
 Application: Yes No  
 Check References: 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: \_\_\_\_\_%  
 Delivery: Yes No # of Employees Involved: \_\_\_\_\_ # of Vehicles Utilized: \_\_\_\_\_ Radius: \_\_\_\_\_  
 Installation: Yes No # of Employees Involved: \_\_\_\_\_ # of Vehicles Utilized: \_\_\_\_\_ Radius: \_\_\_\_\_  
 Details of use, including specifics regarding delivery exposures: \_\_\_\_\_

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: \_\_\_\_\_



13. Does applicant own, operate or lease aircraft? Yes No

If yes, provide details: \_\_\_\_\_

14. Hours of Operation: \_\_\_\_\_

15. Did producer pre-inspect the premises: Yes No

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 #	

<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: \_\_\_\_\_

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.