Republic Indemnity

MACHINE SHOP SUPPLEMENTAL
UNDERWRITING QUESTIONNAIRE

Application/Policy # _____

Insured Name: _____ Federal ID #: _____
Effective Date: _____ Web Site: _____ Insurance Contact E-mail: _____
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:	3632	8742 (1)	8810 (1)	_____
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. What kinds of items are machined? _____
2. What is the average and maximum any part machined would weigh? Average _____ Maximum _____
3. Describe material handling controls in place (e.g. forklifts, hoists, carts, etc.)_____
4. What percentage of employees have the following skill levels? High_____ Medium _____ Low _____
5. Is employee training provided? Yes ◯ No ◯
6. Is the machining considered high tolerance? Yes ◯ No ◯ High precision? Yes ◯ No ◯
7. Total number of machines used in production _____
8. Type of machinery used in production (select all that apply and indicate number):

	Number
CNC (computer-numeric controlled)	_____
Conventional	_____
Metal Forming	_____
Power press	_____
Grinding/Buffing/Polishing	_____

Other ___ Provide details:
_____

9. Is all machinery guarded? Yes ◯ No ◯
10. Are any of the following done? *If yes, provide number of employees involved and details*

Welding	Yes ◯	No ◯	_____
Sandblasting	Yes ◯	No ◯	_____
Heat Treating	Yes ◯	No ◯	_____
Plating	Yes ◯	No ◯	_____
Anodizing	Yes ◯	No ◯	_____
Painting	Yes ◯	No ◯	_____
Assembly	Yes ◯	No ◯	_____

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 _____ # of temporary/seasonal employees _____ # 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 Medical 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. 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. Loss Control Incentive Program: Yes○ No○
13. Percent of Off Premises Operations: _____%
    Delivery: Yes○ No○ # of Employees Involved: _____ # of Vehicles Utilized: _____ Radius _____
    Installation: Yes○ No○ # of Employees Involved: _____ # of Vehicles Utilized: _____ Radius _____
    Details of use, include specifics as to delivery exposures _____
    Number of employees regularly driving: *_____
    *We define regular as over 10% of all production employees time in the aggregate being spent off-premises.
    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* _____
    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○
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*_____

Application/Policy # _____

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

Participating _____ Program_____ Program Name: _____

Commission %_____ Direct Bill _____ Agency Bill _____

Producer Authorized Signature _____ Date_____