



RESTAURANT 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 and 5 rows for payroll data. Columns are labeled 'Class' and rows are labeled 'Current Year', '1st Year Prior', '2nd Year Prior', '3rd Year Prior', and '4th Year Prior'.

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. How would you describe this restaurant?
2. Table service provided: Yes No
3. Hours of Operation:
4. Percentage of liquor sales to food sales: Average entrée price:
5. Check the boxes next to any of the following that are employed: Entertainers, Bouncers, Security Guards
6. Equipment: Are Hobart mixers utilized?
7. Delivery Exposures: % of delivery insured, Radius, % of delivery by third party
Is there a disciplinary/termination rule in place based on driving record?



8. Valet Parking: Yes No If yes, is this performed by the insured's employees: Yes No
Subcontracted with Certificates of Insurance on file? Yes No
If yes, provide details: _____
9. Carpeted dining area: Yes No Split level/multi-story dining area: Yes No
10. Non-skid flooring: Yes No
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General Information

1. Current number of permanent employees: _____ Number of Managers/Supervisors: _____
Number of employees under 18: _____ If any are under 16, work permits on file? Yes No
Number of temporary/seasonal employees: _____ Are any relatives employed? Yes No
Does the insured utilize the services of Temporary Staffing Agencies or Labor Contractors? Yes No
If yes, do they require contract language that specifies that the Agency/Contractor provides Workers' Compensation? Yes No
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. Number of part-time employees _____ Number of full-time employees _____
5. Mean wage: For mainstream employees in production operations or services offered \$ _____/hr.
For administrative staff (e.g. clerical, sales) \$ _____/hr.
6. Union Non-Union % of employees participating _____
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. Loss Control Incentive Program: Yes No
15. Does applicant own, operate or lease 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: _____



Locations(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 #	

Location (1)							
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Street
City, State, Zip

Location (2)							
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Street
City, State, Zip

Location (3)							
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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: _____