# 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** | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Current Year** | | | | | | | | | | |
| **1st Year Prior** | | | | | | | | | | |
| **2nd Year Prior** | | | | | | | | | | |
| **3rd Year Prior** | | | | | | | | | | |
| **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 the **most current experience modification worksheet** if available.

---

**General Information**

1. Detailed description of operations, include end product if applicable, processes used and employees' duties:
   ________________________________________________________________________
   ________________________________________________________________________
2. Is cannabis in any form involved in any processes, or part of end products, or sold stand-alone? If yes, provide details:
   ________________________________________________________________________
3. Current number of permanent employees: __________ Seasonal Employees: _________
   Number of temporary and/or leased 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: __________
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 part time employees __________ Number of full time employees __________
7. Mean wage: For mainstream employees in production operations or services offered $___________/hr.
   For administrative staff (e.g. clerical, sales) $___________/hr.
8. Union Non-Union % of employees participating____________

9. Number of employees working from home: __________
   Average number of days per week working from home: __________
10. 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
11. 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
12. Pre-employment physical: Yes No
13. Drug Screening Program/Random Drug Testing: Yes No
14. Does insured offer modified work? Yes No
    If yes, provide details: ____________________________________________________________________________
15. Hiring Practices
    Application: Yes No
    Check References: Yes No
16. Loss Control Incentive Program: Yes No
17. Percent of Off-Premise Operations: __________% (not applicable to contracting risks)
18. Vehicle Exposure: Yes No Radius of Operations: __________ miles
    Number of Commercial Vehicles: _________ Number of Private Passenger Vehicles: __________
    Details of use, include specifics as to delivery exposures: ______________________________________________
    ____________________________________________________________________________________________
    Number of employees driving on a regular basis?* __________
    *We define regular as over 10% or more of the employees' time.
    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 does the maximum number of covered employees travel together in the same vehicle? ______________
    ____________________________________________________________________________________________
    MVR's checked: Yes No
    If yes, please provide details as to the procedures in place: ____________________________________________
    ____________________________________________________________________________________________
    Is there a disciplinary/termination rule in place based on driving record? Yes No
    If yes, describe how this is implemented: _______________________________________________________
    ____________________________________________________________________________________________
19. Is there any out-of-state travel? Yes No If yes, who travels? ___________________________
    Where do they travel? ______________________ How long do they travel for? ____________________________
20. Does applicant own, operate or lease aircraft? Yes No If yes, provide details: ________________________
    ____________________________________________________________________________________________
21. What is the maximum manual weight lifted? __________ What material handling aids are used? ______________
    ____________________________________________________________________________________________
22. Hours of operation: ____________________
23. 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)** | | | | | | | |
| | | | | | | | |
| Street | | | | | | | |
| | | | | | | | |
| City, State, Zip | | | | | | | |
| **Location (2)** | | | | | | | |
| | | | | | | | |
| Street | | | | | | | |
| | | | | | | | |
| City, State, Zip | | | | | | | |
| **Location (3)** | | | | | | | |
| | | | | | | | |
| 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: _______________