Republic Indemnity

SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

Application/Policy# ______________

Insured Name: ____________________ Federal ID #: ____________________
Effective Date: ____________ Web Site: ____________________ Insurance Email: ____________________
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:	________	________	________	________	________
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 attach **currently valued loss runs** for any of those three years insured elsewhere **and 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 the Agency/Contractor provide Workers' Comp? Yes No
   Number of W2's filed for latest reporting year ____________________

4. Number of employees: Increasing ________ Decreasing ________ Stable ________

5. Number of part time employees ________ Number of full time employees ______________

6. Mean wage: For mainstream employees in production operations or services offered $____________/hr.
   For administrative staff (e.g. clerical, sales) $____________/hr.

7. Union Non-Union % of employees participating ____________

8. 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

9. 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

10. 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

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. Hiring Practices
    Application: Yes No
    Check References: Yes No

15. Loss Control Incentive Program: Yes No

16. Percent of Off Premises Operations: __________% (not applicable to contracting risks)

17. Vehicle Exposure: Yes No Radius of Operations ____________
    #Vehicles______(comm'l) ______ (private passenger)
    Details of use, *include specifics as to delivery exposures*____
    ____

    Number of employees driving: * __________
    *We define regular as over 10% of all production employees time in the aggregate being spent off-premises.
    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 procedures in place ________________
    ____
    Is there a disciplinary/termination rule in place based on driving record? Yes No *If yes, describe how* this is implemented ____

18. Is there any out-of-state travel? Yes No If yes, who travels? ________________________________
    Where do they travel? __________________________ How long do they travel for? __________________________

19. Does applicant own, operate or lease aircraft? Yes No *If yes, provide details* __________________________
    ____

20. What is the maximum manual weight lifted? ___________ What material handling aids are used? _______________
    ____

21. Hours of operation ___________________

22. 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*____

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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

Non Participating Plan_____ Participating _____ Program _____ Program Name: _________________________

Commission %__________ Direct Bill _____ Agency Bill _____

Producer Authorized Signature _______________________________________ Date________________