

Worker's Compensation Supplemental Application

Please fill out complete and submit with other required files to SHall@GMI-Insurance.com

Named Insured(s) _____ Website _____ # of years in business _____

Main Location Address _____

Employer's Contact Information

Insurance Buyer _____ Phone # _____ Email _____

Safety Contact _____ Phone # _____ Email _____

Loss Reports Recipient _____ Phone # _____ Email _____

Employer's Operations

Please provide a complete and detailed description of the employer's operations below or attach separate sheet.

What is the employer's radius of operations in miles, from their place(s) of doing business? _____

Workforce Information

In the space below, or on a separate sheet, list each general job category, the number of employees in each, and the average hourly wage for each category:

General Job Category	Number of Employees	Average Hourly Wages

Provide the information below for each fixed or temporary location with 50 or more employees. Add a separate sheet if needed.

Street Address or Location Name	City	State	Zip Code	# of Occupied Buildings	Total # of Employees Working Here	Max # of Employees Onsite at any one time

If the employer ever uses "day laborers" or hires at job sites provide details: _____

If any employees are paid on a piecework basis provide details: _____

If part-time, temporary, leased and/or volunteer labor is used provide details: _____

If subcontractors are used explain what work is subbed out: _____

Does the hiring process include substance testing? Yes No

Does it include post-offer pre-placement physicals? Yes No

Is there employer contributed medical coverage? Yes No If yes, what % enrolled? _____ %

If a union hall dispatch system is used provide details (flexibility, minimums, etc.): _____

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Prior Payroll & Premium Information

	Current Year	Prior Year	Prior Year	Prior Year	Prior Year
Total Annual Payroll	\$	\$	\$	\$	\$
Premium \$	\$	\$	\$	\$	\$

Employer's Safety Program

- | | | |
|--|------------------------------|-----------------------------|
| Is there a written safety program and rules? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there a full-time safety person? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the employer have regular scheduled safety meetings with employees? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the employer have a formal written Return to Work (RTW) policy and procedure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, please furnish a copy of the policy and procedure with this application. | | |
| Has the RTW policy and procedure been communicated to all current employees? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If no, is the employer willing to develop a formal program with the required elements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Written policy and procedure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Policy and procedure communicated to employees | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| • Make every effort to provide meaningful transitional duty work whenever possible within each injured worker's medical restrictions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does top level management support the Return to Work effort? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Will the employer use a designated medical provider network if requested? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Loss History

For each workers compensation claim in the past 5 years that exceeded \$50,000, describe the cause, the injury type and any corrective action taken by the employer. Attach a separate sheet if preferred.

Employer's Use of Motor Vehicles and/or Mobile Equipment

Provide the number of each type of vehicle operated by employees:

Cars & Light Trucks _____ Medium & Heavy Trucks _____ Tractor Trailer Rigs _____ Vans/Buses _____

In the space below, or on a separate sheet, if employees do operate medium trucks, heavy trucks and/or tractor trailer rigs please describe how the vehicles are used in the business. Please also include how frequently they are used. If any are driven greater than 150 miles from where they are garaged, please explain.

- | | | |
|---|------------------------------|-----------------------------|
| MVRs obtained for all drivers before they are allowed to drive company vehicles? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are MVRs reviewed by management to ensure that they meet acceptability standards? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do employees use personal vehicles on the employer's business? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there ever 4 or more employees in a vehicle together on company business? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, explain below how many vehicles are used for this, how many employees per vehicle, how often this occurs and the typical one-way distance that is driven with four (4) or more in a vehicle.

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If the employer utilizes mobile equipment in their operations, provide details below, including the type of mobile equipment, the number of each type and any special qualifications for employees who operate the equipment. Examples of mobile equipment include forklifts and earth-moving equipment.

Special Exposures

If any current employees have exposure to asbestos, lead, mold, or silica in their work, explain below:

If the employer's prior work exposed employees to asbestos, lead, mold, or silica in their work, explain below:

If any employees have height exposure of 6 feet or greater, explain including the reason for the exposure, the maximum height above floor level and how many employees perform such work and what the safety controls are:

If the business operations include "24-hour" exposures, such as overnight travel, or work that is subject to the bunkhouse rule, please explain the nature, extent, and duration of such work:

If anyone who would be covered by workers compensation flies in a non-commercial aircraft for business purposes, provide details below including how often, who owns the aircraft and where they will travel.

Contractors

Contractors license number _____ Years experience in trade _____

Estimated annual gross sales \$ _____ Estimated number of jobs per year _____

Percentage of work sub-contracted out _____% What type _____

If subs used, does insured: Check annually Directly supervise subs

Indicate percentage of work conducted in each of the following operations (must equal 100% for each)

1)	New Construction:	Remodeling:	Service/Repair:
2)	Commercial:	Apts./Condos/Tract Homes:	Single Custom Homes:
3)	Interior:	Exterior:	

If exterior work done, what is the max height your employees will work above ground level?

Percentage of work/exposure: <12' _____ % 12' to 24' _____ % 24' to 40' _____ % >40' _____ %

What is used? Ladder Scaffolding Scissor Lifts N/A

If insured builds own scaffolding, provide % of annual operations involving scaffold setup and teardown compared to total operations _____%

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Any use of swing scaffolding? Yes No If yes, what percentage of total scaffolding use is swing? _____ %

Any rooftop exposure? Yes No

If yes, what percentage of total work is on commercial flat roof? _____ % What percentage is on pitched rooftop? _____ %

Any work performed on skylights? Yes No If yes, provide details: _____

Any solar work? Yes No If yes, provide details: _____

Fall Protection Program in place? Yes No If yes, please select type below:

Guardrails Safety Belt of Full Body Harness Safety Net Ladder Tie Offs Training in Ladder/Scaffold Placement

Other, please describe: _____

Any concrete tilt-up work? Yes No Self performed? Yes No Subbed to others? Yes No

Does applicant own their cranes or rent them? Own Rent Use their own crane operators or rent? Own Rent

Crane operators CAL OSHA certified? Yes No Employees certified by Tilt-Up Concrete Assoc. (TCA)? Yes No

Are riggers trained and certified? Yes No Provide details: _____

Are Pre-Lift Safety Meetings held? Yes No

Any other use of cranes, booms or similar heavy construction equipment? Yes No

Any work below grade? Yes No Max. depth in feet: _____ % of total work: _____ %

Any confined spaces exposures? Yes No

If yes, please provide details on separate page and include copy of written procedures and details of Confined Spaces Training.

Any work related to wildland fire activities? (fire prevention, work on fireline, work after fire, etc.) Yes No

If yes, provide details: _____

Any work involving asbestos, hazardous product abatement, chemical/petroleum products, USL&H, underground tank or pipe replacement? Yes No If yes, please explain: _____

Does any welding exposure exist? Yes No

If yes, you must complete the Welding Exposure Supplemental App and include it with your submission.

Does this risk conduct work for the government or city municipality? Yes No

Is the applicant involved in "Wrap Up" or "OCIP" projects? Yes No

If yes, please use the space below to provide percentage of total payroll dedicated to these projects and advise detailed procedures on how applicant determines employee split between these projects and other contracts/projects (not Involving "wrap up" or "OCIP").

Indicate percentage of work conducted in each of the following operations or mark not applicable. N/A

Blasting _____% Drilling _____% Light Pole Work _____% Demolition _____% Tunneling _____% Grading _____%

Wrecking _____% Multi-Story Buildings _____% Gas Mains _____% Crane Work _____% Asbestos _____% Highway Work _____%

Scaffold Setup _____% Roofing _____% Excavation _____% Concrete Tilt-Up _____% Sewer _____% Ext. Framing _____%

Structural Steel _____% Bridge Work _____% Supervisory Only _____% Street/Road Work _____% Spray Painting _____%

Dock/Sea Walls _____% Solar _____%

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I hereby apply for a policy of insurance as set forth in the application and I declare that all information contained in this application is correct and complete to the best of my knowledge and belief. I understand that any policy which may be issued by the company will be issued on the basis of and reliance upon my statements in this application. I agree that such policy shall be null and void if such information is false, or misleading, or would materially affect acceptance of the risk by the company.

The signing of this application does not bind the undersigned to purchase the insurance and accepting this application does not bind the Insurer to complete the insurance or to issue any particular policy. If a policy is issued, it is understood and agreed that the Insurer relied upon this application in issuing each such policy and any endorsements thereto. The undersigned further agrees that if the statements in this application change before the effective date of any proposed policy, which would render this application inaccurate or incomplete, notice of such change, will be reported in writing to the Insurer immediately.

The Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.

Applicant

Print Name _____ Signature _____

Title _____ Date _____

I hereby declare that all the information contained in this application is correct and complete to the best of my knowledge and belief, that the application was complete and personally signed by the applicant and that a completed copy hereto has been given to the applicant.

Name of Producing Agency _____

Signature of Producing Agent _____ Date _____