

**Republic
Indemnity**

SUPPLEMENTAL WORKERS' COMPENSATION APPLICATION

Application/Policy# _____

Insured Name: _____ Federal ID #: _____
Effective Date: _____ Web Site Address: _____ Insurance Contact E-mail Address: _____
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	_____	_____	_____	_____	_____
<u>Current</u>	_____	_____	_____	_____	_____
<u>1st Prior Yr</u>	_____	_____	_____	_____	_____
<u>2nd Prior Yr</u>	_____	_____	_____	_____	_____
<u>3rd Prior Yr</u>	_____	_____	_____	_____	_____
<u>4th Prior Yr</u>	_____	_____	_____	_____	_____

Loss Experienc

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

- Detailed description of operations, include end product if applicable, processes used and employees duties:

- Current number of permanent employees _____
Number of temporary/seasonal employees _____
Number of W2's filed for latest reporting year _____
- Number of employees: Increasing Decreasing Stable
- Number of part time employees _____ Number of full time employees _____
- Mean wage: For mainstream employees in production operations or services offered \$ _____/hr.
For administrative staff (e.g. clerical, sales) \$ _____/hr.
- Union Non-Union % of employees participating _____
- Group Medical provided? Yes No Name of Group Health Provider _____
% of employees participating _____ % of employer contribution _____
Paid Vacation? Yes No Paid Sick Leave? Yes No 401K or Pension? Yes No
- Medical Provider Network (MPN) - Please select one: (**applicable to California only**)
Blue Cross of California Prudent Buyer Plan Network and Prudent Buyer Comp Kaiser-on-the-Job
- Pre-employment physical? Yes No
- Drug Screening Program/Random Drug Testing? Yes No
- Does insured offer modified work? Yes No
If yes, provide details _____
- Loss Control Incentive Program: Yes No
- Percent of Off Premises Operations: _____% (not applicable to contracting risks)
- Vehicle Exposure? Yes No Radius of Operations _____
#Vehicles _____(comm'l) _____(private passenger) Group Transportation Provided? Yes No
Details of use, include specifics as to delivery exposures

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* _____

15. Does applicant own, operate or lease aircraft? Yes No

If yes, provide details

16. What is the maximum manual weight lifted? _____

What material handling aids are used? _____

17. Hours of operation _____ Number of Shifts _____

18. 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

Location (s) – Please complete for all locations of business operations:

	# Employees assigned to location (including those who work off premises)	# of Stories/ Floor # occupied by this business	Building Construction Type *(see below)
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 Group Group Name: _____
 Commission % _____ Direct Bill Agency Bill

Producer Authorized Signature _____ Date _____