

SUPPLEMENTAL APPLICATION

Named Insured _____ Effective Date _____ FEIN _____

Loss Control Contact _____ Phone _____ Fax _____

Accounting Contact _____ Phone _____ Fax _____

Claims Contact _____ Phone _____ Fax _____

Incumbent Broker _____ Agency Contact _____ Phone _____

LOSS AND PAYROLL HISTORY

Effective Date	Expiration Date	Earned Premium	Payroll (All Class Codes)

Total Number of Year Round Employees _____ Total Number of Seasonal Employees _____

What Counties does the Insured work in? _____

Wholesale Operations YES NO Pct/Total _____ Retail Operations: YES NO Pct/Total _____

Any changes to the Insured's Normal Anniversary Date YES NO

If YES, Please Explain _____

Health Insurance Provided? YES NO If YES, what employees qualify? MGMNT F/T P/T-SEASONAL

NAME OF HEALTH CARRIER (If applicable) _____

Eligibility Period _____ % Paid by Employer _____ % of Employees Participating _____

Hours of Operation _____

Complete Applications Taken YES NO Reference Checks YES NO Pre/Post Placement Physical YES NO

Average Hourly Wage\$ _____ MVR's Checked YES NO Does Insured subscribe to DMV Pull Program YES NO

Formal IIPP YES NO Safety Meetings YES NO If YES, how often _____

Safety Incentive Program YES NO If YES, details _____

Does Employer have Light Duty Return to Work Programs YES NO Full Time Safety Director YES NO

How are Supervisors/Foremen accountable for injuries? Performance Evaluations: YES NO Mandatory Attendance and Participation in Safety Meetings: YES NO

Are Insured's Products Delivered to Customers by Insured? Wholesale: YES NO Retail :YES NO

Daily Weekly Monthly Average Miles One Way _____ Number of Vehicles _____

Types of Vehicles Used _____

AGRICULTURAL QUESTIONS

Type of Crops _____ Is this risk a Farm Labor Contractor YES NO

Is Harvesting Mechanized YES NO Maintenance Provided by: Insured 3rd Party

Are Ladders Used YES NO How are they paid Piece Rate Hourly Combination

Transportation of Employees YES NO If YES, please complete the Employee Transportation Questionnaire

Housing Exposure YES NO (If YES, please complete the Employee Housing Checklist)

Claimant Name: _____ Date of Loss: _____
Job/Position at Time of Loss: _____ Open Closed Litigation: YES NO
How did Loss Occur: _____

Paid Loss: Indemnity _____ Medical _____ Expense _____
Incurred Loss: Indemnity _____ Medical _____ Expense _____
Was Equipment Involved? YES NO Description of Equipment _____
Did Insured make changes to operations as a result of loss? YES NO IF YES, What were the changes made?

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If more losses are to be reported, copy this page to complete supplemental information