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					
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.

Operational Information

1. Detailed description of operations, include end product if applicable, processes used and employees duties:
____
____
2. Current number of permanent employees______________
Number of temporary/seasonal employees______________
Number of W2's filed for latest reporting year______________
3. Number of employees: ☐ Increasing ☐ Decreasing ☐ Stable
4. Number of part time employees ________ Number of full time employees__________
5. Mean wage: For mainstream employees in production operations or services offered $__________/hr.
For administrative staff (e.g. clerical, sales) $__________/hr.
6. ☐ Union ☐ Non-Union % of employees participating__________
7. 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 ☐
8. 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 ☐
9. Pre-employment physical: Yes ☐ No ☐
10. Drug Screening Program/Random Drug Testing Yes ☐ No ☐
11. Does insured offer modified work?: Yes ☐ No ☐
*If yes, provide details*______________________________
12. Loss Control Incentive Program: Yes ☐ No ☐
13. Percent of Off Premises Operations: __________% (not applicable to contracting risks)
14. 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_________________