



Insured: _____

Web Address: _____

Description of Operations: _____

Is the insured a Professional Employer Organization, Temporary Staffing Organization or Labor Contractor?Yes No

Are There Any Other Commonly Owned Businesses Which Are Separately InsuredYes No

If Yes, Explain: _____

Are There Any States in Which the Insured Operates That Are Covered ElsewhereYes No

If Yes, Explain: _____

PRIOR PAYROLL AND PREMIUM INFORMATION

	Current Year	Prior Year	Prior Year	Prior Year	Prior Year
Premium					
Payroll					

HIRING PRACTICES AND BENEFITS

Written Applications Used Yes <input type="checkbox"/> No <input type="checkbox"/>	Employee Turnover Rate ____%
References Checked Yes <input type="checkbox"/> No <input type="checkbox"/>	Group Medical Benefits Provided Yes <input type="checkbox"/> No <input type="checkbox"/>
Pre-Employment Physicals Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, % of Employees Covered ____%
MVR's Checked Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/>	If work is subcontracted without certificates of insurance, is all payroll included in this submission? Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/>
Volunteer Labor Used..... Yes <input type="checkbox"/> No <input type="checkbox"/>	Is there any interchange of labor between the insured and any other entity which is <u>not</u> included in this submission? Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug Screening (check those that apply):	
Pre-Placement <input type="checkbox"/> Random <input type="checkbox"/> Post-Accident <input type="checkbox"/>	

MANAGEMENT PRACTICES AND LOSS CONTROL

Number of years in business ____ Years	Formal Safety Program..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Owners/Officers Active In Operations Yes <input type="checkbox"/> No <input type="checkbox"/>	Safety Committee..... Yes <input type="checkbox"/> No <input type="checkbox"/>
Any lapse in coverage in the past 24 months? Yes <input type="checkbox"/> No <input type="checkbox"/>	Light Duty / Early Return to Work Program Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the insured been cancelled or non-renewed due to misrepresentation or fraud within the past 3 years?.....Yes <input type="checkbox"/> No <input type="checkbox"/>	Employee Supervision..... Yes <input type="checkbox"/> No <input type="checkbox"/>
	Maximum Weight Lifted Manually: ____ lbs

FINANCIAL CONDITIONS

Has the insured filed for bankruptcy within the last three years?Yes No

Has the insured been self-insured within the last three years? Yes No

If Stop Gap Coverage Is Requested, Provide Annual Premiums Paid in ND, OH, WA, and WY.

If Foreign Travel Exposure Is Requested, Provide Countries Visited, Work Performed And Total Number Of Days Per Year.

If Coverage For Volunteer Labor Is Requested, Provide How Many, Duties, Total Annual Hours For All Volunteers.

If USL&H Is Requested, Provide Class Codes And Actual Exposures.

Signature: _____ Information Supplied By: Broker Insured Date: _____