NBIS

WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION

Named Insured: _____

Insured Email Address* *(Required to Rate)*: _____

FEIN # *(Required to Rate)*: _____

Physical Address: _____

Website: www. _____

Agency Name: _____

Agency Representative: _____

Agent Phone Number: _____

Agent Email Address: _____

How Did You Hear About Us?

☐ Print Advertisement ☐ Tradeshow/Conference ☐ Email Broadcast ☐ Social Media (i.e. Facebook)

☐ Internet Search ☐ Webinar ☐ Postcard ☐ Friend ☐ Other: _____

Description of Operations

Years in Business: _____

Complete Description of Operations: _____

_____

_____

☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Corporation ☐ Joint Venture

Other: _____

Current X Mod: _____ Anniversary Date: _____

Any Acquisitions or Ownership changes in the past two years? Yes ☐ No ☐

Ownership: Active in Management? Yes ☐ No ☐

Number of Full Time Employees: _____

Number of Part Time Employees: _____ Number of Seasonal Employees: _____

Average number of field operations employees: _____

Number of W2's filed for the latest reporting year: _____

Number of Employees are: ___ Increasing ___ Decreasing ___ Stable

Union Affiliation: # Non-Union: # Union:

Mainstream Employees wage per hour: Starting: $ _____ Average: $ _____

Hours of Operation: (#days, hours open) _____ Number of Shifts: _____

Radius of Operation: _____

Transportation Provided? Yes ☐ No ☐ Frequency: _____ Mode: _____

Benefits and Hiring Practices

Group Medical Provided? Yes _____ No _____

Clinic: _____ Physician: _____

Waiting Period for Benefits: _____ Percent Paid by Employer: _____

# of Employees Participating: Dental: _____ Vacation: _____ Paid Sick Leave: _____

Employment Application	☐ Yes	☐ No
References Checked	☐ Yes	☐ No
Pre-Employment Physicals	☐ Yes	☐ No
Pre-Placement Audiogram	☐ Yes	☐ No
Drug Screening Program – Pre-Placement	☐ Yes	☐ No
Drug Screening Program – Post Accident	☐ Yes	☐ No
Written Disciplinary Procedure in Place	☐ Yes	☐ No
Drug/Alcohol Rehab Program	☐ Yes	☐ No
Employee Assistance Programs	☐ Yes	☐ No
Return to Work Program	☐ Yes	☐ No
Does Insured Offer Modified Work Schedule	☐ Yes	☐ No
Any Interchange of Labor	☐ Yes	☐ No
Certificates of Insurance Obtained	☐ Yes	☐ No
Any Sports or other Recreational Activities Allowed on Premises	☐ Yes	☐ No

Name/Title of Person Conducting Interviews:

How are Qualifications of Employees Verified?

Safety Practices

Name and Title of Person Responsible for Safety: _____

Name and Title of Primary Claims Contact: _____

Claims/Losses Incident Rate: _____ Severity Rate: _____

Written Safety Program	☐ Yes	☐ No
Safety Program Accountability	☐ Yes	☐ No
• Back Injury Prevention Program	☐ Yes	☐ No
• Code of Safe Practices (Written & Enforced Company Safety Rules)	☐ Yes	☐ No
• Employee/Management Safety Incentive Program	☐ Yes	☐ No
• Fall Protection Program, Height Exposure _____	☐ Yes	☐ No
• Fleet Safety Program: # Vehicles _____, MVR's _____%, Company Used _____	☐ Yes	☐ No
• Maintain Your Own Vehicles	☐ Yes	☐ No
• Haz Com Program	☐ Yes	☐ No
• Lockout/Tagout Program	☐ Yes	☐ No
• Trenching Safety Program, Maximum Depth _____	☐ Yes	☐ No
• Management Incent Investigation	☐ Yes	☐ No
• Mobile equipment Training Program	☐ Yes	☐ No
• Personal Protective Equipment Program	☐ Yes	☐ No
New Employee Orientation	☐ Yes	☐ No
Employee Safety Training (Documented)	☐ Yes	☐ No
Substance Abuse Policy	☐ Yes	☐ No

Hazardous Conditions Abatement Documentation	☐ Yes	☐ No
Workplace Safety Inspections	☐ Yes	☐ No
Smoking Allowed on job Sites/Premises	☐ Yes	☐ No
OCIP (Owner/Contractor Insurance Programs)	☐ Yes	☐ No
Delivery Exposure:	☐ Yes	☐ No

Delivery Frequency: Delivery Radius:

Contractor's Operations

Commercial _____% Industrial _____% Residential _____% Service/Repair _____%

New _____% Remodel _____% Demolition _____% SubContract _____%

Do employees work more than 3 stories above ground being raised by lifts or hoisting devices?: ☐ Yes ☐ No

If yes, how high?: _____

Percentage of operations that is sub-out trucking: _____%

Does insured utilize owner operations?: ☐ Yes ☐ No

If yes, what percentage of operation: _____%

Percentage of operations exceeds 200 mile radius: _____

What is the insured hauling and what percentage is:

Coil _____% Rolled or Steel Beams _____% General Freight _____% Hazardous Material _____%

Percentage of payroll from Stand Alone Rigging: _____ %

Out of State Travel – Description of Operations: _____

Employees involved in Out of State Travel: _____ Location: _____

Frequency of Travel: Duration of Travel: Days/ Months

USL&H

Is "if any" contractual USL&H needed?	☐ Yes	☐ No
Is any work done on a ship, shipyard or marina? If yes, circle OVER, NEAR, or ADJACENT TO navigable waterway	☐ Yes	☐ No
Is any work done on a barge? If yes, circle OVER, NEAR, or ADJACENT TO navigable waterway	☐ Yes	☐ No
Is any work done on a navigable waterway? (waterway with the capacity to provide access directly or indirectly to interstate or international waters) If yes, circle OVER, NEAR, or ADJACENT TO navigable waterway	☐ Yes	☐ No
Is any work done on any bridge? If yes, circle OVER, NEAR, or ADJACENT TO navigable waterway	☐ Yes	☐ No
Is any work done on port authority property? If yes, circle OVER, NEAR, or ADJACENT TO navigable waterway	☐ Yes	☐ No
Is the USL&H exposure state specific? List states:	☐ Yes	☐ No
Confirm understanding of USL&H provided is incidental only	☐ Yes	☐ No
The Agent and the Insured understand that any changes in operations pertaining to USL&H must be reported within thirty (30) days	☐ Yes	☐ No

Will the applicant own, lease, charter or borrow any watercraft on a navigable waterway?	☐	Yes	☐	No
Will the applicant employ anyone as a Master or Member of the crew of any watercraft on a navigable waterway?	☐	Yes	☐	No
Will the applicant employ anyone to perform any work on or from a watercraft under navigation?	☐	Yes	☐	No
Will the applicant contract any work to be performed on or from a watercraft under navigation without reviewing proof of maritime coverages for the contractor's workers?	☐	Yes	☐	No

ATTENTION

1. THE APPLICANT WARRANTS THAT THE ABOVE STATEMENTS AND PARTICULARS, TOGETHER WITH ANY ATTACHED OR APPENDED DOCUMENTS OR MATERIALS ("THIS APPLICATION"), ARE TRUE AND COMPLETE AND DO NOT MISREPRESENT, MISSTATE OR OMIT ANY MATERIAL FACTS.
2. THE APPLICANT UNDERSTANDS THAT THE COMPANY RELIED UPON THE INFORMATION CONTAINED WITHIN THIS APPLICATION TO DETERMINE ACCEPTABILITY, RATES AND COVERAGE.
3. THE APPLICANT UNDERSTANDS THAT ANY MISREPRESENTATION OR OMISSION SHALL CONSTITUTE GROUNDS FOR RESCISSION OF COVERAGE AND DENIAL OF CLAIMS, OR, AT THE OPTION OF THE COMPANY, THE ASSESSMENT OF ADDITIONAL PREMIUM CHARGES. THE APPLICANT REPRESENTS AND WARRANTS TO THE COMPANY THAT, IF A POLICY IS ISSUED TO THE APPLICANT, THE APPLICANT WILL COOPERATE WITH THE COMPANY IN CONNECTION WITH ANY INSPECTION, PREMIUM AUDIT AND IN ALL OTHER RESPECTS AS REQUIRED UNDER THE POLICY.
4. THE APPLICANT UNDERSTANDS THE COMPANY IS NOT OBLIGATED NOR UNDER ANY DUTY TO ISSUE A POLICY OF INSURANCE BASED UPON THIS APPLICATION. THE APPLICANT FURTHER UNDERSTANDS THAT, IF A POLICY IS ISSUED, THIS APPLICATION WILL BE INCORPORATED INTO AND FORM A PART OF SUCH POLICY.
5. IF THE APPLICANT BECOMES AWARE THAT ANY RESPONSE ON THIS APPLICATION IS INACCURATE AS A RESULT OF INFORMATION OR CHANGE OF CIRCUMSTANCES BEFORE A POLICY IS ISSUED, THE APPLICANT MUST INFORM THE COMPANY OF SUCH CHANGE, IN WRITING, AND ANY POLICY ISSUED BEFORE SUCH NOTIFICATION IS SUBJECT TO IMMEDIATE CANCELLATION.
6. THE APPLICANT AUTHORIZES THE COMPANY TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THE APPLICATION AS IT MAY DEEM NECESSARY.

THE UNDERSIGNED, BEING AUTHORIZED BY AND ACTING ON BEHALF OF THE PROSPECTIVE INSUREDS, REPRESENTS THAT THE ANSWERS GIVEN ARE TRUE. FAILURE TO PROVIDE TRUTHFUL ANSWERS AND ALL MATERIAL INFORMATION CAN RESULT IN THE COMPANY ELECTING TO CANCEL, REFORM AND/OR RESCIND THE POLICY.

("APPLICANT", "YOU", "YOUR" AND SIMILAR WORDS REFER TO THE PROSPECTIVE INSURED)

THE TERMS, CONDITIONS AND EXCLUSIONS CONTAINED IN POLICIES ISSUED BY THE COMPANY VARY SIGNIFICANTLY FROM THOSE CONTAINED IN MANY OTHER LIABILITY INSURANCE POLICIES. THE POLICY FORM ISSUED BY THE COMPANY PROVIDES COVERAGE THAT MAY BE MORE LIMITED THAN THAT AVAILABLE UNDER THE "ISO" INSURANCE POLICY OR SIMILAR TYPES OF POLICIES. YOU SHOULD CAREFULLY REVIEW THE ENTIRE POLICY WITH YOUR AGENT, LEGAL COUNSEL OR OTHER INSURANCE PROFESSIONAL TO MAKE SURE THAT YOU UNDERSTAND THE COVERAGE IT PROVIDES, AND YOUR RIGHTS AND OBLIGATIONS UNDER THE POLICY.

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Signature of Applicant	**Date**
Title (Officer, Manager, Partner, Owner)	
Signature of Broker	**Date**

**As an associated party to NBIS, you will be notified via e-mail about products or services that may be of interest to you. To opt-out from these program updates, please go to NBIS.com, then Contact Us, and select Opt-Out Request.*