

# GLADIUS INSURANCE SERVICES

## Cannabis Supplemental

Named Insured:				
Website:				
Detailed Description of Operations:				
Hours of Operation:				
Operations Include (check all that apply):	<input type="checkbox"/> Dispensary	<input type="checkbox"/> Growing	<input type="checkbox"/> Processing	<input type="checkbox"/> Delivery
Employees (# of Each):	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Volunteers
How are Employees Paid:	<input type="checkbox"/> Hourly	<input type="checkbox"/> Commission	<input type="checkbox"/> Salary	<b>Other:</b>
Benefits Offered (check all that apply):	<input type="checkbox"/> Paid Sick Time	<input type="checkbox"/> Paid Vacation	<input type="checkbox"/> 401k	<input type="checkbox"/> Retirement
Group Health Coverage:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If yes, % paid by employer:</b> <input type="checkbox"/> %	
Pre Hire (check all that apply):	<input type="checkbox"/> Written Application	<input type="checkbox"/> Reference Checks	<input type="checkbox"/> Physicals	
	<input type="checkbox"/> Pre-Hire Drug Testing	<input type="checkbox"/> Random Drug Testing	<input type="checkbox"/> Post Accident Drug Testing	
	<input type="checkbox"/> Pre-Hire MVR Checks	<input type="checkbox"/> Annual MVR Checks	<input type="checkbox"/> Criminal Background Checks	
<b>Other, please list:</b>				
Return-To-Work/Light Duty Available:	<input type="checkbox"/> Formal/Written	<input type="checkbox"/> Informal/Verbal	<input type="checkbox"/> None	
Subcontractors Used:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>If yes, what % of payroll:</b> <input type="checkbox"/> %	
Are COIs Obtained for Subs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Employee Average Annual Turnover:	<input type="checkbox"/> %			
Day Laborers or Employee Leasing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Safety Program in Place:	<input type="checkbox"/> Formal/Written	<input type="checkbox"/> Informal/Verbal	<input type="checkbox"/> None	
Safety Training:	<input type="checkbox"/> Yes, Documented	<input type="checkbox"/> Yes, Verbal	<input type="checkbox"/> None	
Safety Meetings:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, frequency:	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Annually
MSDS Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Chemicals Used: (herbicides/pesticides)	<b>Please List:</b>			<input type="checkbox"/> N/A
Respiratory Program in Place:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Building Properly Ventilated:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Lifting Exposures:	<input type="checkbox"/> <25lbs	<input type="checkbox"/> 25-40lbs	<input type="checkbox"/> 40+lbs	<input type="checkbox"/> N/A
Machinery Guarded & Maintained:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Lockout/Tagout:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Forklifts Used:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <b>Check Box if Operators Are Annually Certified</b>	
Maximum Height in Feet:	<input type="checkbox"/> 0-6 Feet	<input type="checkbox"/> 7-15 Feet	<input type="checkbox"/> 15 Feet and Above	<input type="checkbox"/> N/A
If heights, what is used:	<input type="checkbox"/> Scissor Lift	<input type="checkbox"/> Scaffolding	<input type="checkbox"/> Bucket Truck	<input type="checkbox"/> Ladder
<b>Other, please describe:</b>				
Type(s) of Fall Protection:	<input type="checkbox"/> Fall Arrest	<input type="checkbox"/> Positioning	<input type="checkbox"/> Retrieval	<input type="checkbox"/> Suspension
Provide details regarding what the insured has implemented to keep employees safe in response to COVID19:				
<b>Other, please list:</b>				
List all Personal Protective Equipment:	<input type="checkbox"/> Gloves	<input type="checkbox"/> Back Belts	<input type="checkbox"/> Protective Clothing	<input type="checkbox"/> Ear Plugs
	<input type="checkbox"/> Goggles	<input type="checkbox"/> Non-Slip Shoes	<input type="checkbox"/> Steel Toed Boots	<input type="checkbox"/> Masks
	<input type="checkbox"/> Hard Hats	<b>Other, please list:</b>		
Driving or Delivery Mileage % of Each:	<input type="checkbox"/> <50	<input type="checkbox"/> 50-100	<input type="checkbox"/> 100+	<input type="checkbox"/> N/A
Group Transportation:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>If yes, # of Employees:</b> <input type="checkbox"/> #	
Are Vehicles Company Owned:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> <b>Check Box if Owned Vehicles are Unmarked</b>	
Vehicle Maintenance Program:	<input type="checkbox"/> In-House	<input type="checkbox"/> Outside Vendor	<input type="checkbox"/> No	
Distracted Driving policy in place:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A	
Drivers Training:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> N/A	
CDL's Required:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	
Overnight Travel by Employees:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>If yes, frequency:</b>	
Average Distance Driven Per Day:	<input type="checkbox"/> Minimum	<input type="checkbox"/> Maximum	<input type="checkbox"/> N/A	
Average # of Deliveries Per Day:	<input type="checkbox"/> Minimum	<input type="checkbox"/> Maximum	<input type="checkbox"/> N/A	
If Out of State Transport, List States:				
Security Systems Used (check all that apply):	<input type="checkbox"/> Interior Camera(s)	<input type="checkbox"/> Metal Detector	<input type="checkbox"/> Panic Button	

Security Systems Used (continued):	<input type="checkbox"/> Exterior Camera(s)	<input type="checkbox"/> Central Station Burglar Alarm	<input type="checkbox"/> Metal Doors
	<input type="checkbox"/> Gated Doors	<input type="checkbox"/> Central Station Fire Alarm	<input type="checkbox"/> Door Intercom
	<input type="checkbox"/> Gated Windows	<input type="checkbox"/> Security Vestibule/Mantrap	

**Other Security:**

Written Security Plan (including what to do in the event of robbery):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Security Guards:	<input type="checkbox"/> Insured's Employees	<input type="checkbox"/> Outside Security Firm Personnel	<input type="checkbox"/> N/A
Security Guards Armed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Outside Security Company Used:	<input type="checkbox"/> Check Box if COI's are Obtained	<input type="checkbox"/> Check Box if Insured is named as an Additional Insured on Security Company's GL Policy	
Extraction Method(s) Used:	<input type="checkbox"/> CO2	<input type="checkbox"/> Butane	<input type="checkbox"/> Isopropyl
	<input type="checkbox"/> Ethanol	<input type="checkbox"/> Water	<b>Other, please list:</b>

Please Describe Extraction Process in Detail:

Is there a 3rd party maintenance agreement on the CO2 Equipment or any other methods listed above Equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is the extraction operation segregated from other operations including explosive proof wiring?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Does the system have emergency relief valves due to the accumulation of pressure in the process?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Are all emergency relief valves should be piped to the outside of the building?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is the extraction being done in a Class C1D1 Booth? If not, what type of booth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Other Type:</b>
Extraction Training Provided:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Emergency Plan in Place in case of toxicity, fire, .	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Square footage of Grow Area:			
Flow Meters or Water Timers Used:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**Affirmation**

The undersigned acknowledges and understands the information provided herein will be used to evaluate the applicant and a decision as to whether the applied to insurance company will offer workers' compensation insurance will be made, in part, based on the information provided. Signature below indicates the information provided is true and correct. This Supplemental Application must be signed by a principle, owner or partner of the entity applying for insurance.

**Owner/Officer Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_