

GLADIUS INSURANCE SERVICES

General Supplemental

Named Insured: _____

Website: _____

Detailed Description of Operations: _____

Hours of Operation: _____

Driving or Delivery Mileage % of Each: <50 50-100 100+ N/A

Group Transportation: No Yes **If yes, # of Employees:** #

Are Vehicles Company Owned: No Yes N/A

Vehicle Maintenance Program: In-House Outside Vendor No

Distracted Driving policy in place: No Yes N/A

Drivers Training: No Yes N/A

Overnight Travel by Employees: No Yes **If yes, frequency:** _____

Employees (# of Each): Full Time Part Time Seasonal Volunteers

How are Employees Paid: Hourly Commission Salary **Other:** _____

Benefits Offered (check all that apply): Paid Sick Time Paid Vacation 401k Retirement

Group Health Coverage: Yes No **If yes, % paid by employer:** %

Pre Hire (check all that apply): Written Application Reference Checks Physicals
 Pre-Hire Drug Testing Random Drug Testing Post Accident Drug Testing
 Pre-Hire MVR Checks Annual MVR Checks Criminal Background Checks

Other, please list: _____

Return-To-Work/Light Duty Available: Formal/Written Informal/Verbal None

Employee Average Annual Turnover: %

Subcontractors Used: No Yes **If yes, what % of payroll** %

Are COIs Obtained for Subs: Yes No N/A

Day Laborers or Employee Leasing: Yes No

Safety Program in Place: Formal/Written Informal/Verbal None

Safety Training: Yes, Documented Yes, Verbal None

Safety Meetings: Yes No

If yes, frequency: Weekly Monthly Quarterly Annually

Lifting Exposures: <25lbs 25-40lbs 40+lbs N/A

Machinery Guarded & Maintained: Yes No N/A

Lockout/Tagout: Yes No N/A

Forklifts Used: No Yes **Check Box if Operators Are Annually Certified**

Maximum Depth in Feet: 0-3 Feet 4-7 Feet 8 Feet and Below N/A

Maximum Height in Feet: 0-6 Feet 7-15 Feet 15 Feet and Above N/A

If heights, what is used: Scissor Lift Scaffolding Bucket Truck Ladder

Other, please describe: _____

Provide details regarding what the insured has implemented to keep employees safe in response to COVID19: _____

List all Personal Protective Equipment: Gloves Back Belts Protective Clothing Ear Plugs
 Goggles Non-Slip Shoes Steel Toed Boots Masks
 Hard Hats **Other, please list:** _____

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: _____