

# Construction Supplemental Application



Insured: \_\_\_\_\_ FEIN: \_\_\_\_\_ Eff. Date: \_\_\_\_\_  
 Contact Name & Title: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Fax.#: \_\_\_\_\_  
 Website Address: \_\_\_\_\_

Years in business: \_\_\_\_\_ #of Locations: \_\_\_\_\_  
 Description of operations: \_\_\_\_\_  
 Union:  Yes  No If yes, name of Union: \_\_\_\_\_  
 Current number of employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Volunteers \_\_\_\_\_  
 Percent of employee turnover in the last 12 Months: Full time \_\_\_\_\_ Part time \_\_\_\_\_  
 Employee staffing expectation over the next 12 months: Full time \_\_\_\_\_ Part time \_\_\_\_\_  
 Average hourly wage in Governing Class: Full time \$ \_\_\_\_\_ Part time \$ \_\_\_\_\_  
 Average hourly wage in Clerical Class: Full time \$ \_\_\_\_\_ Part time \$ \_\_\_\_\_  
 Average hourly wage in Sales Class: Full time \$ \_\_\_\_\_ Part time \$ \_\_\_\_\_  
 Has the insured ever been in bankruptcy?  Yes  No  
 If yes, Explain \_\_\_\_\_

Are ALL employees eligible Y/N; if no the who? \_\_\_\_\_

	% paid by employer	% of participation
Group Health <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Paid sick leave <input type="checkbox"/> Yes <input type="checkbox"/> No	Vacation <input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement / Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Healthcare provider: _____		
Do you use specific:	Clinic _____	Physician _____
		Emergency room _____
Full time nurse maintained on staff?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
CPR training provided?: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Safety program / IIPP compliant with SB 198  Yes  No  
 Return to light duty plan  Yes  No  
 Return to full time modified work plan  Yes  No  
 Designated full time safety director  Yes  No Name: \_\_\_\_\_  
 Safety meetings held for all employees  Yes  No Frequency of meetings: \_\_\_\_\_  
 Safety training for all employees  Yes  No Incentive program for employees  Yes  No  
 Personal protective safety equipment provided  Yes  No  
 Supervisors are held accountable for injuries/accidents  Yes  No  
 Accident investigation program in place  Yes  No

Employment application <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No
Reference checks <input type="checkbox"/> Yes <input type="checkbox"/> No	Audiometric Testing <input type="checkbox"/> Yes <input type="checkbox"/> No
Motor Vehicle Record Check <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre/Post employment physical <input type="checkbox"/> Yes <input type="checkbox"/> No
Volunteer labor used <input type="checkbox"/> Yes <input type="checkbox"/> No	Pathogenic test (i.e. lead) <input type="checkbox"/> Yes <input type="checkbox"/> No
Temporary labor used <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic back test <input type="checkbox"/> Yes <input type="checkbox"/> No

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Hours of operation: \_\_\_\_\_ to \_\_\_\_\_ Number of daily shifts: \_\_\_\_\_  
 Operation includes driving?  Yes  No Number of authorized drivers \_\_\_\_\_ No. of vehicles \_\_\_\_\_  
 Types of vehicles driven \_\_\_\_\_  
 Reason(s) for driving (delivery, sales calls, etc.)? \_\_\_\_\_  
 Frequency of driving: Daily  Weekly  Other  \_\_\_\_\_  
 Driving radius: < 50 miles  51-100 miles  101-250 miles  > 250 miles   
 Frequency of MVY checks \_\_\_\_\_ Participation in CHP Pull program  Yes  No  
 Driver acceptability standards have been established  Yes  No  
 Vehicles inspection / maintenance program  Yes  No Frequency \_\_\_\_\_  
 Vehicle maintenance performed is performed by employees  Yes  No  
 Employees take vehicles home  Yes  No

**Payroll Current Year** \_\_\_\_\_  
**1st Prior Year** \_\_\_\_\_  
**2nd Prior Year** \_\_\_\_\_  
**3rd Prior Year** \_\_\_\_\_

**Premium Current Year** \_\_\_\_\_  
**1st Prior Year** \_\_\_\_\_  
**2nd Prior Year** \_\_\_\_\_  
**3rd Prior Year** \_\_\_\_\_

Any travel out of state?  Yes  No No.# of employees who travel: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Purpose: \_\_\_\_\_

Contractor's license number? \_\_\_\_\_ Years experience in trade? \_\_\_\_\_  
 Estimated annual gross sales? \_\_\_\_\_ Estimated # of jobs per year? \_\_\_\_\_  
 Percentage of work sub-contracted out? \_\_\_\_\_ % What type? \_\_\_\_\_  
 If subs used, does insured:  Check annually?  Directly supervise subs?  
 Average # of certificates collected annually? \_\_\_\_\_ Average # of Waivers of Subrogation needed? \_\_\_\_\_  
 Indicate % of work conducted in each of the following operations (must equal 100% for each):  
 New Construction \_\_\_\_\_ Remodeling \_\_\_\_\_ Service/Repair \_\_\_\_\_  
 Commercial \_\_\_\_\_ Single Custom Homes \_\_\_\_\_ Apts/Condos/Tract Homes \_\_\_\_\_  
 Interior \_\_\_\_\_ Exterior \_\_\_\_\_ If exterior work done, what is the maximum height exposure? \_\_\_\_\_  
 Any use of cranes, booms or similar heavy construction equipment?  Yes  No  
 Any work below grade?  Yes  No Max Depth in feet \_\_\_\_\_ % of total work  
 Any confined spaces exposures?  Yes  No  
 If yes, please provide details on separate page – include copy of written procedures and details of Confined Spaces Training.  
 Any work involving asbestos, hazardous product abatement, chemical/petroleum products, USL&H, underground tank or pipe replacement?  Yes  No If yes, please explain \_\_\_\_\_  
 Does this risk conduct work for the government or city municipality?  Yes  No  
 Is the applicant involved in "Wrap Up" or "OCIP" projects  Yes  No  
 If yes, please provide percentage of total payroll dedicated to these projects, and advise detailed procedures on how applicant determines employee split between these projects and other contracts/projects (not Involving "wrap up" or "OCIP")

Indicate % of work conducted in each of the following operations or Mark not applicable  N/A

Blasting _____	Drilling _____	Light Pole Work _____	Demolition _____	Tunneling _____
Grading _____	Wrecking _____	Multi Story Buildings _____	Gas Mains _____	Crane Work _____
Asbestos _____	Highway Work _____	Scaffold set-up _____	Roofing _____	Concrete Tilt-up _____
Sewer _____	Exterior Framing _____	Structural Steel _____	Bridge Work _____	Excavation _____
Supervisory only _____	Street/road work _____	Spray painting _____	Dock/Sea Walls _____	

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Does insured work within 2 miles of the following building or facilities:

- Government or Military base:  Yes  No
- Financial Institutions including national/regional stock exchange  Yes  No
- Sport Stadiums/ Arenas and Theme Parks  Yes  No
- Major Bridges, Tunnels or Dams  Yes  No
- Utilities or Power Generation Plants  Yes  No
- Transportation Hubs, Railroads, Airports or Shipping  Yes  No
- Historic/Symbolic buildings, monuments or parks  Yes  No

**EXPOSURE INFORMATION – PREMISES – FIX LOCATION – EMPLOYEES**

Total number of employee's: \_\_\_\_\_

State	Location #	Payroll	Total # of Employees	# of Shifts	Maximum # of Employees Per Shift	Type of Building (See List Below)	Year Built	# of Stories	Floors Occupied
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							

If additional locations exist please include on a separate form.

Type of Building: (1.) Steel 3 stories or greater (2.) Frame 3 stories or less (3.) Concrete tilt up

- 1. Has the Insured previously participated in a Medical Provider Network?  Yes  No
- 2. Is the insured willing to participate in a Medical Provider Network?  Yes  No

Comments:

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THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND CERTIFIES THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE CERTIFIES THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE