Retail / Wholesale

Supplemental Application

Empire Underwriters, LLC
INSURANCE MANAGERS & WHOLESALERS

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 ☐ Yes ☐ No	_____	_____

Paid sick leave ☐ Yes ☐ No Vacation ☐ Yes ☐ No Retirement / Pension Plan ☐ Yes ☐ No
Name of Healthcare provider: _____
Do you use specific: Clinic_____ Physician_____ Emergency room _____
Full time nurse maintained on staff?: ☐ Yes ☐ No
CPR training provided?: ☐ Yes ☐ 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	☐ Yes ☐ No	Drug/substance abuse	☐ Yes ☐ No
Reference checks	☐ Yes ☐ No	Audiometric Testing	☐ Yes ☐ No
Motor Vehicle Record Check	☐ Yes ☐ No	Pre/Post employment physical	☐ Yes ☐ No
Volunteer labor used	☐ Yes ☐ No	Pathogenic test (i.e. lead)	☐ Yes ☐ No
Temporary labor used	☐ Yes ☐ No	Orthopedic back test	☐ Yes ☐ 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		Premium	
	Current Year_____		**Current Year**_____
	1st Prior Year_____		**1st Prior Year**_____
	2nd Prior Year_____		**2nd Prior Year**_____
	3rd Prior Year_____		**3rd Prior Year**_____

Any travel out of state? ☐ Yes ☐ No No.# of employees who travel: _____Frequency: _____
Purpose:_____

Gross receipts:

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

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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:

_____

_____

_____

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