Metro Insurance Services • *Lic#OB95215*
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p. 714.573.7200 • f. 714.573.7202

Contractors Supplemental App

Insured: ______________________ Eff Date: ____________ FEIN No.: ______________

Contact Name: ____________________ Contact Title: ______________________________

Telephone: ____________________ Fax: ____________________

Insured History

Years in business: ______ **if less than 5**; number of years in trade: _____ No. of locations: __________

Description of Operations: ____

Out of state exposure: Yes No **If yes**; name of states: __________ Foreign Travel: Yes No

Present number of employees: ____ Full-time employees ____ 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: $ _____ Full-time $ _____ Part-time $ _____ Any Piece work compensation

Benefits provided - are ALL employees eligible? Yes No **If no;** who is eligible: ______________

			% 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: ____

Provide name of clinic, physician, or emergency room used for work place related injury:

____

Full-time nurse maintained on staff: Yes No

CPR training provided: Yes No

Indicate the safety activities currently established and practiced regularly:

Is Owner active in daily operations: Yes No **If yes;** *duties performed:* ______________

Safety program / IIPP in use compliant with SB 198? Yes No

Return to light duty plan: Yes No Includes full wages? 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 held for all employees: Yes No *Incentive program for employees:* Yes No

Slip and Fall Prevention Program in place: Yes No

Hazardous Materials Communication program in place: Yes No

Personal Protective safety equipment provided for all employees Yes No **If yes;** what type:

____

Supervisors are held accountable for injuries / accidents Yes No

Accident investigation program in place Yes No

METRO INSURANCE SERVICES

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Hiring Practices

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

Operations

Hours of operation: ___________ to ___________ No. of daily shifts:_______ No. of days per week:_____

Operation includes delivery: Yes No No. of authorized drivers: _____ No. of vehicles: ________

Frequency of delivery: Daily Weekly Other, explain: ____________________

Delivery radius: <50 miles 51-100 miles 101-250 miles >250 miles

Frequency of MVR checks: ________________ Participate in CHP Pull Program: Yes No

Driver acceptability standards have been established: Yes No

Vehicle inspection / maintenance program: Yes No *Frequency:* ______________

Vehicle maintenance is performed by employees: Yes No

Employees take vehicles home at night: Yes No

Contractors

Contractors License Number: ____________________________

Percentage of new construction: ______% Residential ______% Commercial ______% Industrial

Percentage of remodeling: ______% Residential ______% Commercial ______% Industrial

Percentage of repair work: ______% Residential ______% Commercial ______% Industrial

Percentage of work subcontracted: ______ %

Any work performed above 2 stories: Yes No **If yes,** explain: ____________________

Any Roof Exposure: Yes No **If yes**, explain: ____________________

Details of Interior and/or Exterior work performed: ____________________

Any use of Cranes: Yes No **If yes**, explain: ____________________

Any use of Scaffolds: Yes No **If yes**, are the ee's certified? ____________________

Any Excavation exposure: Yes No **If yes**, explain depth: ____________________

Are deliveries made: Yes No *Frequency:* Daily Weekly Other: ______________

Delivery radius: Under 50 miles 50-100 miles Over 100 miles

Vehicles owned: Yes No **If yes**, take home: Yes No

Vehicle maintenance program: Yes No

MVR "Pull" program: Yes No **If yes,** how often: ____________________

Any changes in operations in the last 5 years: Yes No **If yes**, describe: ______________

____

Condition of equipment: Excellent Good Poor

Any job site security provided: Yes No **If yes**, describe: ____________________

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Payroll and Premium History

Payroll

Current Year: ____________________
1st Prior Yr. ____________________
2nd Prior Yr. ____________________
3rd Prior Yr. ____________________

Premium

Current Year: ____________________
1st Prior Yr. ____________________
2nd Prior Yr. ____________________
3rd Prior Yr. ____________________

State	Class Code	Description	Payroll	# of employees	Governing wage

Catastrophe Exposure

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

Medical Provider Network Compliance

1. IF THIS APPLICATION IS **NEW** BUSINESS TO THE CARRIER:
   Has the Insured previously participated in a Medical Provider Network? Yes No
   Is the Insured willing to participate in Clarendon/TMC MPN? Yes No

2. IF THIS APPLICATION IS **RENEWAL** BUSINESS TO THE CARRIER:
   Has the Insured implemented the Clarendon/TMC MPN? Yes No
   If yes, when?
   If not, will the Insured implement the Clarendon/TMC MPN during the next policy term? Yes No

Signature

Signature: ______________________________ Title: __________________________ Date: ____________