All City Insurance

Workers' Compensation

Landscaping Supplemental Application

Applicant Name: _____	Effective Date: _____
Federal ID No.: _____	Web Address: _____
Phone Number: _____	Email Address: _____

Producer currently writes applicant's work comp coverage? ☐ Yes ☐ No Current lapse in coverage? ☐ Yes ☐ No

Additional Coverages: ☐ Waiver of Subrogation – Blanket ☐ Voluntary Compensation ☐ USL&H
☐ Waiver of Subrogation - Specific ☐ Repatriation ☐ Other: _____

Preferred Pay Plan ☐ Monthly Report of Payroll ☐ Monthly Stipulated Installments ☐ Other: _____

Regulatory authority filing required? ☐ Yes ☐ No ☐ PUC # _____ ☐ DMV MCP # _____ ☐ DOT #_____

A. PRIOR PAYROLL, PREMIUM, AND CARRIER INFO

Term	Total Annual Payroll	Premium	Carrier
Current	$	$	
1st Prior	$	$	
2nd Prior	$	$	
3rd Prior	$	$	
4th Prior	$	$	

B. OPERATIONS

1. States of operations: ☐ CA ☐ NV ☐ Others: _____

2. Does the applicant have any plans to begin operations in states not listed B.1. above? ☐ Yes ☐ No

3. Owners active in daily operations? ☐ Yes ☐ No If yes, excluded from coverage? ☐ Yes ☐ No

4. Hours of operations: From: _____ To: _____ 5. Number of shifts: _____

6. 24-hour exposure? ☐ Yes ☐ No If yes, what is exposure? _____

7. Year business established: _____

8. New venture or acquisition of an existing business? ☐ Yes ☐ No
   If yes: Years of experience in this industry: _____
   Does owner(s) own other businesses? ☐ Yes ☐ No
   Purchasing a pre-existing business? ☐ Yes ☐ No
      If yes: Date of acquisition: _____
      Current management being retained? ☐ Yes ☐ No If yes, what percentage? _____%
      Current employees being retained? ☐ Yes ☐ No If yes, what percentage? _____%
      Prior loss runs available? ☐ Yes ☐ No
   Commencing to do business for the first time? ☐ Yes ☐ No
   Hiring employees for the first time? ☐ Yes ☐ No
   Does applicant have employees and is operating without WC coverage? ☐ Yes ☐ No

9. Driving / delivery exposure? ☐ Yes ☐ No ☐ N/A
   If yes: Purpose of driving / delivery operations:
   ☐ Sales / Consulting ☐ Delivery ☐ Test Drive ☐ To / From Job Sites
   ☐ Other: _____
   Frequency: ☐ Daily ☐ Weekly ☐ Other: _____
   Radius of driving/delivery:

0 - 25 Miles _____%	101 - 200 Miles _____%	1,001 – 1,500 Miles _____%
26 - 50 Miles _____%	201 - 500 Miles _____%	Over 1,500 Miles _____%
51 - 100 Miles _____%	501 – 1,000 Miles _____%	

   Maximum radius: _____ miles
   # of vehicles used: Cars _____ Trucks _____ Vans _____ Buses _____ Other: _____
   # of authorized drivers: _____
   Group transportation of employees (more then 3 employees in same vehicle)? ☐ Yes ☐ No
      If yes: Frequency of trips involving group transportation: ☐ Daily ☐ Weekly ☐ Other: _____

All City Insurance

Company vehicles taken home? ☐ Yes ☐ No
Employees use personal vehicles for company use? ☐ Yes ☐ No
Vehicle/fleet maintenance program? ☐ Yes ☐ No ☐ By Employees ☐ By Outside Vendors
Fleet safety program? ☐ Yes ☐ No
Driver acceptability standards program? ☐ Yes ☐ No
MVRs checked before or after hire? ☐ Yes ☐ No
MVRs checked annually? ☐ Yes ☐ No
Enrollment in DMV "Pull" Program? ☐ Yes ☐ No

10. Heights of operations: (must equal 100%): ☐ N/A

% of Operations	Accessed Via				
0 to 6 feet _____%	☐ Ladders	☐ Scaffolding	☐ Cherry Picker / Boom	☐ Scissor Lift	☐ Other: _____
7 to 15 feet_____%	☐ Ladders	☐ Scaffolding	☐ Cherry Picker / Boom	☐ Scissor Lift	☐ Other: _____
16 to 25 feet_____%	☐ Ladders	☐ Scaffolding	☐ Cherry Picker / Boom	☐ Scissor Lift	☐ Other: _____
26 to 35 feet_____%	☐ Ladders	☐ Scaffolding	☐ Cherry Picker / Boom	☐ Scissor Lift	☐ Other: _____
Over 35 feet _____%	☐ Ladders	☐ Scaffolding	☐ Cherry Picker / Boom	☐ Scissor Lift	☐ Other: _____

Maximum height of operations: _____ feet
If scaffolding is used is it erected by employees? ☐ Yes ☐ No If yes, are employees certified annually? ☐ Yes ☐ No
Formal/documented fall protection program? ☐ Yes ☐ No If yes, copy available? ☐ Yes ☐ No

11. Depths of operations: (must equal 100%): ☐ N/A

% of Operations
0 feet _____%
1 to 3 feet _____%
4 to 6 feet _____%
More than 6 feet _____%
Maximum depth of operations: _____ feet
Trench box or shoring required? ☐ Yes ☐ No

12. Manual lifting exposure? ☐ Yes ☐ No ☐ N/A

If yes, Under 20 lbs. _____%
21 to 40 lbs. _____%
41 to 50 lbs. _____%
Over 50 lbs. _____%
(must equal 100%)
Formal lifting policy? ☐ Yes ☐ No
Supplemental lifting devices used? ☐ Yes ☐ No

13. Employees work from home? ☐ Yes ☐ No If yes, type of work: _____

14, Out of state, international, or overnight (within state) travel? ☐ Yes ☐ No

If yes: Why / Purpose: _____
Who will travel: _____ Where: _____
Duration: _____ Frequency: _____

15. # employees live or work out of state: Live: _____ Work: _____

16. Number of employees: Full Time: _____ Part Time: _____ Seasonal: _____ Volunteers: _____

If volunteers: Duties of volunteers: _____
Work comp coverage requested for volunteers? ☐ Yes ☐ No
Accident, Health, or Disability Insurance provided to volunteers by applicant? ☐ Yes ☐ No

17. Last 12 months employee turnover: ☐ <10% ☐ 11-20% ☐ 21-30% ☐ >30% If >20%, why? _____

18. Next 12 months employee count forecast: ☐ Stable ☐ Increasing ☐ Decreasing

19. Maximum # of employees at any one location: _____

20. # W-2's issued last year: _____ Previous year: _____

21. Employees paid: ☐ Hourly ☐ Flat Salary ☐ Commission ☐ Piece rate ☐ Other: _____

22. Employee to supervisor ratio: ☐ <4:1 ☐ 4:1 ☐ 5:1 ☐ 6:1 ☐ 7:1 ☐ >7:1

23. % of union employees: _____ % of non-union employees? _____

24. Day laborers or temporary / employee leasing? ☐ Yes ☐ No
If yes, please provide details: _____

25. Average hourly wage for employees in governing class: $_____/hour

26. Average employee tenure with the company: _____ years

27. Does applicant hire temporary labor in states where they are working on a temporary basis? ☐ Yes ☐ No ☐ N/A

28. Are there any employees exempt from workers' compensation (e.g. casual labor, domestic servants, etc.)? ☐ Yes ☐ No

29. Does the applicant ever "borrow" a worker from another employer? ☐ Yes ☐ No

30. Are there any employees from a PEO? ☐ Yes ☐ No

All City Insurance

31. Interchange of labor? ☐ Yes ☐ No
If yes: ☐ Another Business ☐ A Subsidiary ☐ Between Departments ☐ Other: _____

32. Subcontractors used? ☐ Yes ☐ No If yes, why? _____
If yes, certificates of insurance kept on file? ☐ Yes ☐ No

33. Are independent contractors used? ☐ Yes ☐ No If yes, why: _____
If yes, how paid: ☐ 1099's ☐ Other: _____

C. EMPLOYEE BENEFITS

1. Group medical plan provided?	☐ Yes ☐ No	
If yes: Provider name? _____	% of employees enrolled? _____	% paid by the employer? _____
2. Paid sick leave?	☐ Yes ☐ No	
3. Paid vacation?	☐ Yes ☐ No	
4. Retirement or pension plan?	☐ Yes ☐ No	Employer contribute? ☐ Yes ☐ No
5. Specific medical provider used to treat injured employees?	☐ Yes ☐ No	☐ Clinic ☐ Physician ☐ Other: _____ Distance to provider? _____ miles
6. Medical Provider Network (MPN)?	☐ Yes ☐ No	MPN name? _____
7. CPR training provided?	☐ Yes ☐ No	Number of certified employees? _____

D. HIRING AND EMPLOYEE PRACTICES

1.	Written applications?	☐ Yes	☐ No	Hearing tests?	☐ Yes	☐ No
	Reference checks?	☐ Yes	☐ No	Orthopedic back testing?	☐ Yes	☐ No
	Criminal background checks?	☐ Yes	☐ No	Pathogenic (disease) testing?	☐ Yes	☐ No
	Pre-hire drug / substance abuse testing?	☐ Yes	☐ No	Formal job descriptions on file?	☐ Yes	☐ No
	Post-accident drug/substance abuse testing?	☐ Yes	☐ No	Job-specific training provided?	☐ Yes	☐ No
	Pre or post hire employment physicals?	☐ Yes	☐ No	New employee orientation?	☐ Yes	☐ No
2. Personnel files documented for pre-existing injuries?		☐ Yes	☐ No			

E. LOSS CONTROL AND SAFETY

1.	Active injury & illness prevention program?	☐ Yes	☐ No		
	Written safety program?	☐ Yes	☐ No	☐ English ☐ Spanish ☐ Other: _____	
	Safety training / orientation?	☐ Yes	☐ No	☐ Formal/Documented ☐ Informal	
	Safety meetings?	☐ Yes	☐ No	Frequency? _____	
	Active safety incentive program?	☐ Yes	☐ No	Type of incentive? _____	
	Safety director or risk manager?	☐ Yes	☐ No	Full time position? ☐ Yes ☐ No	
	Written accident reporting policy?	☐ Yes	☐ No		
	Written accident investigation procedure?	☐ Yes	☐ No		
	Supervisors accountable for injuries / accidents?	☐ Yes	☐ No		
	Return to work program?	☐ Yes	☐ No	Salary continuation included? ☐ Yes ☐ No	
	Specific job training?	☐ Yes	☐ No		
	Forklift training?	☐ Yes	☐ No	☐ N/A	
	Machinery/equipment property guarded?	☐ Yes	☐ No	☐ N/A	
	Written lockout / tagout / blockout procedures?	☐ Yes	☐ No	☐ N/A	
	Respiratory program?	☐ Yes	☐ No	☐ N/A	
	Office ergonomic safety program?	☐ Yes	☐ No	☐ N/A	
	Personal protective safety equipment?	☐ Yes	☐ No	☐ N/A	

If yes: ☐ Back Belts ☐ Boots ☐ Safety glasses ☐ Hearing Protection ☐ Respiratory Equipment
☐ Gloves ☐ Guard Rails ☐ Safety belts ☐ Ladder Tie Offs ☐ Full Body Harnesses
☐ Safety Nets ☐ Other: _____

2. OSHA citation in last year? ☐ Yes ☐ No If yes, please explain: _____

3. Loss control services performed in last year? ☐ Yes ☐ No
If yes, required recommendations completed? ☐ Yes ☐ No

All City Insurance

F. OTHER CONSIDERATIONS

1. Bankruptcy (ever)? ☐ Yes ☐ No If yes, in last five years? ☐ Yes ☐ No	
2. Years at current location: _____	3. Age of occupied building: _____ years
4. Building / Premises: ☐ Owned ☐ Leased	5. Condition of premises: ☐ Excellent ☐ Very Good ☐ Good ☐ Average
6. Equipment condition: ☐ New ☐ Good ☐ Average ☐ N/A	
7. Equipment operators trained and currently certified? ☐ Yes ☐ No ☐ N/A	
8. Average claim reporting timeframe: _____ days	
9. Any claim over $25,000 in last four years? ☐ Yes ☐ No If yes, please provide the following information for each such claim:	
How did it occur? Is employee still working for the applicant?	
What was the injury? What corrective action has the applicant taken to prevent reoccurrences?	

10. **This section must be completed by all applicants who are individuals, sole proprietorships, husband and wife,or partnerships (where the general partners are husband and wife).**

Please list below any relatives residing in your household who are employees of your business and to whom your books and records show payments to such relatives:

Employed Relatives*

Name	Relationship to You	Job Title or Duties	Estimated Annual Remuneration

☐ Check here if there are no relatives residing in your household that are employed in your business.

***Relatives are defined as: spouse, child by birth or adoption, stepchild, grandchild, son-in-law, daughter-in-law, parent, step-parent, parent-in-law, grandparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, sister-in-law, uncle, aunt, nephew, or niece.**

Note: Per California Labor Code, as an employer you are required to include in your Workers' Compensation coverage all relatives residing in your household who are your employees. Any policy issued based on information provided in this application will exclude coverage for residing relatives if none are listed above.

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Arrowhead General Insurance Agency, Inc. must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Underwriter must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Applicant Name _____ Date _____

Signature _____

All City Insurance

LANDSCAPING

1. Applicant licensed? ☐ Yes ☐ No If yes, license number: _____

2. Indicate % of work conducted in each of the following operations:
Residential: _____ % Commercial: _____ % Municipal: _____ % Other: _____ (must equal 100%)
Mantenance: _____ % Installation/Contruction: _____ % (must equal 100%)

3. Indicate % of operations. If none apply, ☐ N/A

_____ Boulder removal (>50 lbs)	_____ Spraying of pesticides/fertilizers
_____ Debris removal or clear cutting	_____ Sprinkler installation
_____ Hardscape work	_____ Tree planting (>25 gallons)
_____ Highway, roadway, or median work	_____ Tree removal (>10 feet)
_____ Holiday Decorations installation / removal	_____ Tree Trimming* (off the ground)
_____ Mow and Blow	_____ Trenching
_____ Reforestation	_____ Use of chippers, mulchers, cherry pickers, booms or similar equipment
_____ Snow removal	_____ Use of tractors, loaders or similar equipment

4.*Tree Trimming indicated above: ☐ Yes ☐ No
Ladders? ☐ Yes ☐ No Lifts? ☐ Yes ☐ No Tree climbing: ☐ Yes ☐ No If yes, maximum height: _____ ft
No. of certified arborists: _____ No of TCIA Tree Care Specialists: _____
Is tree care work restricted to a specific crew or specific individuals? ☐ Yes ☐ No

5. Any installation / removal of box trees larger than 5 gallons? ☐ Yes ☐ No

6. Is there a disciplinary program for fall protection safety violations? ☐ Yes ☐ No
(Note: A copy of OSHA approved Fall Protection Program may be requested to secure binding)

7. Are all job sites inspected prior to accepting contracts? ☐ Yes ☐ No

8. Is any utility line clearance work peformed? ☐ Yes ☐ No If yes, percentage of payroll in the last 12 months? _____%