

**WORKER'S COMPENSATION  
Supplemental Application  
Underwriting Information**

Name Insured ( list all names) \_\_\_\_\_

\_\_\_\_\_

National Van Line Affiliation(s)? \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
Does applicant operate or own any business other than a moving and storage operation? If yes, please explain.	_____	_____
Does applicant lease employees from an employee leasing firm? If yes, attach a copy of the leasing agreement.	_____	_____
Does applicant check references of all full and part time employees prior to their date of hire?	_____	_____
Does applicant check acceptability of MVR's prior to hiring employees who drive company vehicles or drive their own vehicles on company business?	_____	_____
Does applicant participate in a DMV pull program (If available)?	_____	_____
Does applicant require pre-employment drug testing of all drivers, packers, and handlers?	_____	_____
Does applicant conduct random drug testing of all drivers, packers, and handlers?	_____	_____
Does applicant conduct a team safety incentive program?	_____	_____
Does applicant have a safety program?	_____	_____
Any losses over \$50,000? If yes, provide details and describe corrective action taken.	_____	_____

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Yes**                      **No**

Does applicant utilize owner operators? \_\_\_\_\_

If yes, do contractors procure their own workers' compensation coverage and does insured have current certificates of insurance? \_\_\_\_\_

If no, are contractors to be covered under master WC policy of applicant? \_\_\_\_\_

Please provide annual gross 1099 revenue of all contractors to be insured under the master policy \$ \_\_\_\_\_

Please multiple by .25 for CA Risks /.33 for all other states and include in Payroll estimates on application and note accordingly.

**If Mover's Choice is to provide WC coverage for contractors please provide list of contractors, their 1099 revenue and appropriate named insured and DBA Listing for policy issuance.**

Material Changes in the past five years? Date Occurred \_\_\_\_\_  
If yes provide details. \_\_\_\_\_

Any expected or Potential changes in the upcoming Policy year?  
If yes provide details. \_\_\_\_\_

Group medical offered to eligible employees? Percent of employee participation \_\_\_\_\_% \_\_\_\_\_

Retirement programs or Life insurance for drivers? \_\_\_\_\_

Modified/Light Duty Return to Work Program? \_\_\_\_\_

Are all drivers (including intra-state) DOT qualified? \_\_\_\_\_

Respond to the question below based on the exposure of the applicant's employees or owner operators who do not have WC insurance working under their authority.

Radius of Operations	0-50 Miles	51-100 Miles	101-250 Miles	Over 250 Miles
	%	%	%	%

Please provide radius of operations of your employees to be covered under this WC policy, please do not include hauling where the workers' compensation exposure is done by long distance contractors or van line contractors insured elsewhere.

Remarks:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

