

MAVERICK SUPPLEMENTAL APPLICATION

Insured: _____ Eff Date: _____ FEIN NO. _____
 Contact Name & Title: _____ Tel. No.: _____ Fax No.: _____

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 not then who is eligible? _____

| | % 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: _____
 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

HIRING PRACTICES:

| | |
|---|---|
| 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 |

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 _____
 Delivery radius: < 50 miles 51-100 miles 101-250 miles >250 miles
 Frequency of MVR checks _____ Participation 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

PAYROLL AND PREMIUM HISTORY:

Payroll : Current Yr. _____
1st Prior Yr. _____
2nd Prior Yr. _____
3rd Prior Yr. _____

Premium: Current Yr. _____
1st Prior Yr. _____
2nd Prior Yr. _____
3rd Prior Yr. _____

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

EXPOSURE INFORMATION – PREMISES - FIXED 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 included on a separate form.

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

MEDICAL PROVIDER NETWORK COMPLIANCE:

1. IF THIS APPLICATION IS NEW BUSINESS TO PRAETORIAN:

Has the Insured previously participated in a Medical Provider Network? Yes No
Is the Insured willing to participate in the Praetorian/TMC MPN? Yes No

2. IF THIS APPLICATION IS RENEWAL BUSINESS TO PRAETORIAN:

Has the Insured implemented the Praetorian/TMC MPN? Yes No
If yes, when?
If not, will the Insured implement the Praetorian/TMC MPN during the next policy term? Yes No

Signature: _____ Title: _____ Date: _____

THIS FORM MUST BE FILLED OUT IF IT APPLIES TO THE INSURED

HOTEL / MOTEL:

Number of guest rooms: _____ Room rate: Under \$50 \$50-74.95 \$75-99 Over \$100
Food service: Operate own: Yes No Subcontract: Restaurant Bar Both
Gross receipts: Food _____% Liquor _____%
Entertainment: Yes No Lounge: Yes No Armed Security: Yes No
Operation: Year round Seasonal Conference center: Yes No
Shuttle service: Yes No How many vans: _____
How are maids compensated: Salary Hourly wage Flat rate per room
Who flips the mattresses and how are they turned: _____

RETAIL / WHOLESALE:

Gross receipts: Wholesale _____% Retail _____%
Compensation: Flat salary _____ Hourly wage _____ Type of merchandise: _____
Outside sales employees: Yes No Commission _____
Lifting exposure or repackaging: Yes No Lbs: _____ Is there assembly: Yes No
If yes, describe? _____

MANUFACTURING:

Machine guarding: Point of operation: Yes No Drive mechanism: Yes No Moving Parts: Yes No
Computer operated equipment: Yes No
Material handling exposure: Yes No Lifting: Below 50 lbs. Above 50 lbs. _____
Off premises operations: Yes No Percentage _____ Where / What: _____

TYPE OF MACHINES USED? _____

SERVICE STATIONS / AUTO REPAIR SHOPS / TRANSMISSION SHOPS:

Hours of Operation _____ Mini-Market: Yes No Liquor sold? Yes No
Gas operation: Full Service Self service Bullet proof cashier booth: Yes No
Repair operation: Yes No Drop safe or registers: Yes No
 Tire repair/installation : Split Rim Over 1-ton truck Car Wash: Yes No If yes, self serve full serve
Towing: Yes No Contract tow: Yes No Access to freeway: 0-1 mile 1-2 miles 2+ miles

ATTORNEYS:

What type of law: _____
Any criminal law: Yes No
Any insurance law: Yes No

RESTAURANT:

Average Entrée Price: _____ Take-out: Yes No % of revenues _____
Liquor Receipts (% of gross receipts) _____ Catering Yes No % of revenues _____
Separate Lounge: Yes No Delivery Yes No % of revenues _____
Twenty-four hour operation: Yes No Valet Parking Yes No
Number of: Hosts _____ Wait-staff _____ Cooks _____
Bartenders _____ Radius of delivery area _____
Entertainment: Yes No If yes, please provide details: _____

APARTMENT OWNER OR OPERATOR:

List of operations sub-contracted to others: _____
Any tenants perform sub-contracted operations for you? Yes No If yes, please list: _____
The following items are maintained and kept current for all sub-contractors:
Certificate of workers' compensation insurance Yes No
Copy of each sub-contractor's license number Yes No
List of current sub-contractors and contractor's license numbers: _____

(If more than 3 provide a separate list)

*****THIS FORM MUST BE FILLED OUT IF IT APPLIES TO THE INSURED*****

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: _____

FARMS:

| Crops Grown | Avg. Acreage | Harvested Mechanically | Type of Equipment |
|-------------|--------------|------------------------|-------------------|
| | | YES / NO | |
| | | YES / NO | |
| | | YES / NO | |
| | | YES / NO | |
| | | YES / NO | |
| | | YES / NO | |

1: How many acres: 160 or less 161-499 500-999 1,000+
 2: Housing Provided: Yes No If so, how many employees _____
 3: Transportation of employees: Yes No How: Van Bus Airplane Other
 Frequency: Daily Weekly Monthly Radius _____
 4: Use Labor Contractor: Yes No
 5: Employees pay: Hourly rate _____ Piece rate _____ Combination _____ Other _____
 6: Operation outside of California: Yes No
 7: Dairy Barn: Elevated Carousel Flat Other _____
 a) Number of Milking cows _____
 b) Number of Bulls _____ Number of Bulls 3 years old & older: _____
 c) Outside Veterinary Services: Yes No
 d) Artificial Insemination: Yes No Subcontracted: Yes No
 e) Hoof trimming: Yes No Subcontracted Yes No
 f) De-horn: Yes No Subcontracted Yes No
 8: Does insured harvest crops for others: Yes No If so, own equipment used: Yes No

TRUCKING EXPOSURES:

1. Commodities Hauled – Breakdown by % of Revenue: _____
 2. Type of Equipment – Type of Number of Vehicles:
 Flatbed _____ Tractor Trailer _____ Double Trailer _____ Tank _____
 Refrigerated _____ Other _____
 3. Do drivers load and unload cargo? Yes No If yes, how often: _____% palletized loads? Yes No
 4. Type of Carrier Truckload(TL) Less than Truckload (LTL)
 5. Number of Drivers: _____ b. Average age of Drivers: _____ c. Average age of Vehicles: _____

COMPLETE PAGE #5 IF MORE THAN 100 EMPLOYEES PER LOCATION

Reinsurance Information: Must be completed for each location with 100+ employees

Location #1

Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? Yes No If yes – year completed: _____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____

Reinsurance Information: Must be completed for each location with 100+ employees

Location #2

Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? Yes No If yes – year completed: _____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____

Reinsurance Information: Must be completed for each location with 100+ employees

Location #3

Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? Yes No If yes – year completed: _____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____

Reinsurance Information: Must be completed for each location with 100+ employees

Location #4

Street address: _____ City: _____ State: ___ Zip code: _____
Number of employees at this location: _____ Hours of operation: _____ Number of shifts: _____
Type of construction: Frame (Code 1)___ Joisted Masonry (Code 2) ___ Non-combustible (Code 3) ___
Masonry non-combustible (Code 4) ___ Modified fire resistive (Code 5)___ Fire resistive (Code 6) ___
Seismically retrofit? Yes No If yes – year completed: _____
Age of building: _____ Number of floors: ___ Specific floors occupied: _____
Location is: Single building: __ Multi-building: __ Urban: ___ Suburban: ___ Rural: ___
Class codes: _____
Payroll by class code: _____