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| *Please provide list of Named Insureds, ownership structure of each & operation of each entity. If entities have separate FEINS, please include those along with the combinability with the first Named Insured.*Please list. | Date: Click or tap to enter a date. |
| Complete Description of Operations: Please explain. |
| **CONTACT INFORMATION** |
|  | **Contact Name** | **Phone Number** | **E-Mail** |
| Inspections: | Please list. | Please list. | Please list. |
| Premium Audit: | Please list. | Please list. | Please list. |
| Claims: | Please list. | Please list. | Please list. |
| **PRIOR PAYROLL AND PREMIUM INFORMATION** |
|  | **Total Annual Payroll** | **Premium** |  | **Total Annual Payroll** | **Premium** |
| Expiring Policy Year: | Please list. | Please list. | 2nd Prior Year: | Please list. | Please list. |
| 1st Prior Year: | Please list. | Please list. | 3rd Prior Year: | Please list. | Please list. |
| **OPERATIONS** |
| Years in business Years | Hours of Operations Please list. | Number of Shifts# |
| # of Employees:  | Full Time # | Part Time # | Seasonal # | # of temporary positions held # | Name of temp agency Please list. |
| Any Volunteers? Yes/No | How many? # | Number of hours worked # | List duties Please list. |
| Do employees use personal vehicles for company business? Yes/No | DMV Pull Program or MVRs run annually? Yes/No |
| Actual average hourly wage for EE’s in governing class? **$** $$ | **/hr** | Number of W-2’s issued this year and last year # |  |
| Are you currently participating in a MPN (Medical Provider Network)? Yes/No  | If yes, please provide the name of current MPN. Please list. |  |
| Do you currently have a Return to Work program? Yes/No | If yes, does it include salary continuation? Yes/No |  |
| Has ownership changed in last 5 years? Yes/No | Any out of state or international travel? Yes/No |
| Does employer provide: Sick leave? Yes/No | Vacation? Yes/No |
| **HIRING PRACTICES/EMPLOYEE SELECTION** |
| Written Applications?  | Yes/No | Reference Checks? | Yes/No | Pre-hire drug testing? | Yes/No | Post-accident drug testing? | Yes/No |
| MVR Checks? Yes/No | Formal job descriptions on file? Yes/No | Do you have a formal written accident report? Yes/No |
| Is job specific training provided? Yes/No | Does employer provide group health plans? Yes/No | % paid by employer 0 **%** | % participation: 0 **%** |
| Employee Orientation Program? Yes/No | If yes, is the orientation: [ ]  Verbal only  [ ]  Verbal and Documented | Are you performing pre-employment/ post-hire physicals?  |  Yes/No [ ]  N/A |
| **SAFETY PROGRAM** |
| Are owners active in daily operations? Yes/No | Have loss control services been performed? Yes/No | Last OSHA inspection? Please list. |
| Do employees receive safety training? Yes/No | If yes, is the training: [ ]  Formal/Documented [ ]  Informal |
| If forklifts are used is training provided? Yes/No | Is all machinery properly guarded? Yes/No | What types of PPE? Please list. |
| Formal lifting policy? | Yes/No | Have all workers been instructed in proper lifting techniques? Yes/No |  |
| **SELF-STORAGE OPERATIONS** |
| Does a resident manager live on premises? Yes/No | Does the insured lease or loan vehicles to tenants to move their belongings? Yes/No If yes, describe. Please explain.  |
| If insured owns/leases autos, are they serviced by insured’s employees or outside entities? Make selection. |
| **Hours of Operation** | How does the insured store and/or stock merchandise if they sell ancillary items? Please explain. |
|  | **OPEN** | **CLOSE** |
| Weekday | 00:00 AM/PM | 00:00 AM/PM |
| Weekend | 00:00 AM/PM | 00:00 AM/PM |
| **TRANSPORTATION EXPOSURES** |
| Number of vehicles? # Number of employees traveling in one vehicle at a given time? # Radius traveled? # miles |
| **SELF-STORAGE SECURITY** |
| How is access to the storage facility and individual units controlled? Please explain. |
| What procedures does the insured use to protect its employees from attacks by disgruntled tenants? Please explain.  |
| Are employees instructed to alert local law enforcement and not to intervene in an ongoing robbery of storage units? Please explain. |
| Are armed/unarmed security on site? Yes/No | If yes, describe. Please explain.  |
| Do the security personnel carry other forms of protection, including mace, tasers, pepper spray? Yes/No | If yes, describe. Please explain.  |
| Does insured provide Active Shooter Training? Yes/No | If yes, describe. Please explain.  |

All of the information herein is true and correct to the best of my knowledge. I have not knowingly or intentionally concealed or misrepresented any fact. This form will become part of the insurance application and as such all fraud statements are applicable.

Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance containing false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Applicant Name: Enter Text.

Title: Enter Text.

Date: Click or tap to enter a date.