LEASED EMPLOYEES PROVIDED TO OTHERS APPLICATION

APPLICANT INFORMATION

NAME:	
MAILING ADDRESS:	
PROPOSED EFF DATE: **FROM:** **TO:**	**WEBSITE:**
FORM OF BUSINESS: ☐ **INDIVIDUAL** ☐ **PARTNERSHIP** ☐ **JOINT VENTURE** ☐ **CORPORATION** ☐ **LIMITED CORPORATION** ☐ **SUBCHAPTER "S" CORPORATION** ☐ **NOT FOR PROFIT ORG** ☐ **OTHER**	**YEARS IN BUSINESS**

PREMISES INFORMATION

LOC#	BLD#	STREET, CITY, STATE, ZIP CODE	INTEREST	YR BUILT	PART OCCUPIED

DESCRIPTION OF OPERATIONS BY PREMISE(S)

PRIOR CARRIER INFORMATION

CATEGORY	YEARS:	YEARS:	YEARS:	YEARS:
CARRIER				
POLICY NUMBER				
POLICY TYPE	☐ Claim Made ☐ Occ.	☐ Claim Made ☐ Occ.	☐ Claim Made ☐ Occ.	☐ Claim Made ☐ Occ.
RETRO DATE	/ /	/ /	/ /	/ /

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PRIOR CARRIER INFORMATION continued

CATEGORY	YEARS:	YEARS:	YEARS:	YEARS:
GENERAL LIABILITY LIMITS				
E & O LIMITS				
TOTAL PREMIUM				

LOSS HISTORY

ENTER ALL CLAIMS OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS

☐ CHECK HERE IF NONE ☐ SEE ATTACHED LOSS SUMMARY

DATE OF OCCURRENCE	LINE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	OPEN/ CLOSED

COVERAGES / LIMITS

COVERAGES	LIMITS
☐ **COMMERCIAL GENERAL LIABILITY** ☐ Occurrence ☐ Claims Made Retroactive Date:	**GENERAL LIABILITY** Each Occurrence Limit $
☐ **PROFESSIONAL LIABILITY** ☐ Occurrence ☐ Claims Made Retroactive Date:	Damage To Premises Rented To You Limit $ Medical Expense Limit $ Personal and Advertising Injury Limit $
DEDUCTIBLE - PER CLAIM General Liability (PD & BI) $ Errors and Omissions * $ * Minimum $1,000 under program	General Aggregate Limit $ Products/Completed Operation Aggregate Limit $ **ERRORS OR OMISSIONS** Each Claim $
Other Coverages	

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SCHEDULE OF HAZARDS

Location #	Classification	Class Code	Premium Basis	Terr

GENERAL INFORMATION

Explain all "YES answers	YES	NO
1. Is the applicant a subsidiary of another entity or does the applicant have any subsidiaries?	☐	☐
2. Is a formal safety program in operation?	☐	☐
3. Any exposure to flammables, explosives or chemicals?	☐	☐
4. Any policy or coverage declined, cancelled or non-renewed during the prior 3 years?	☐	☐
5. Any past losses or claims relating to sexual abuse or molestation allegations, discrimination or negligent hiring?	☐	☐
6. Attach a blank copy of the employment application you require of people desiring to be registered with you. 6a. Attach a blank copy of the agreement between you and your customer, the company seeking to lease employees from you.		
7. Do you provide health care benefits to the people registered with you?	☐	☐
8. Do you provide vacation benefits to the people registered with you?	☐	☐
9. Do you provide Workers Compensation to the people registered with you? 9a. What company provides the worker's comp? _____ 9b. What is the Coverage B limit? _____ 9c. Policy Number _____	☐	☐

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GENERAL INFORMATION continued

10. Provide 3 year (minimum) Work Comp premium and loss information:

Policy Term	Policy Number	Audited Premium	Paid Loss Amounts*	Res Loss Amounts*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Provide description below of any individual loss, paid or reserved over $2,500.

11. Nature and Quantity of Exposure

Number of people registered with you available for leasing (as of the date you are completing this Supplemental Application):

a. Clerical (meaning typists, computer operators, file clerks, general office workers) _____
b. Commercial/Mercantile (meaning retail store clerks, food service workers, cleaning and janitorial workers, outside salespeople, residential maintenance and repair workers [not construction or remodeling workers], in-town drivers and helpers engaged in delivery _____

c. Other Specialty Category (Explain and provide details) _____

12. Total Payroll - payroll receipts from category of employees:

Type	Last 12 Months	First Year Prior	Second Year Prior
Clerical	_____	_____	_____
Commercial/Mercantile	_____	_____	_____
Other	_____	_____	_____

13. Total Payroll receipts ANTICIPATED for the next 12 months from:

Clerical _____ Commercial/Mercantile _____ Other _____

LEASED EMPLOYEES PROVIDED TO OTHERS APPLICATION

GENERAL INFORMATION continued

14. Describe for each category of employee, the TRAINING, TESTING, EDUCATION, and BACKGROUND checking you provide (use an additional page if necessary).

    Clerical:

    Commercial/Mercantile:

    Other:

Remarks:

The applicant agrees, represents and warrants that the statements and information contained in the application for insurance, including all statements, information and documents accompanying or relating to the application are accurate and complete and no facts have been suppressed, omitted or misstated. Failure to fully disclose the information requested in the application for insurance, whether by omission or suppression, or any misrepresentation in the statements, information and documents accompanying or relating to the application, renders coverage for any claim(s) null and void and entitles us to rescind the policy from its inception.

Signature of Applicant*: _____ Title: _____

Agency: _____ Producer Code:_____ Date: _____

***Signing this application does not bind the applicant or the company to complete the insurance.**

Delaware Valley Underwriting Agency, Inc.

ADDENDUM TO APPLICATION

Insured's/Applicant's Name: _____

TO BE ATTACHED TO AND MADE A PART OF ALL APPLICATIONS

It is agreed that the following FRAUD STATEMENTS are attached to the application:

APPLICABLE IN THE STATE OF PENNSYLVANIA:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICABLE IN THE STATE OF NEW YORK:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

APPLICABLE IN ALL OTHER STATES:

WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. (Not Applicable in CO, HI, NE, OH, OK, OR, IN, DC, LA, ME and VA insurance benefits may also be denied)

I have read and accept the above (To be signed by the Insured/Applicant)

Insured/Applicant Signature Date