## CONTRACTOR SUPPLEMENTARY WORKERS COMPENSATION APPLICATION

LEMIC INSURANCE COMPANY C/O CCMSI Post Office Box 6967 Metairie, Louisiana 70009 PHONE: (866) 314-9970 FAX: (866) 883 8413

NAME OF APPLICANT: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_\_

CITY/ STATE/ ZIP: \_\_\_\_\_

## GENERAL EXPOSURE INFORMATION

Description of Operations:

Number of years in business under the above name / operation.

Prior Workers Compensation Coverage:

\_\_\_\_Yes \_\_\_\_No

Name of Current Carrier:

a. If none, provide the owner(s) experience in managing or operation this type of business:

Does the applicant own (or is affiliated with) any business other than this one?

\_\_\_\_\_Yes \_\_\_\_\_No (if yes, please explain)

What percentage of work performed (must equal 100%)

RESIDENTIAL	COMMERCIAL	OTHER
New Construction	New Construction	New Construction
Renovation	Renovation	Renovation
TOTALS:		

What is the total number of employees listed under Direct Payroll in which a W2 is filed?\_\_\_\_\_

Out of that number...How many Full Time Employees \_\_\_\_\_ How many Part Time Employees \_\_\_\_\_

Based on the above work exposures, indicate the anticipated percentage of work performed over the next 12-months under the exposures listed. (Direct – Employee Payroll / Contracted Work – Sub)

Type of Work	% Dir	% Sub	Type of Work	% Dir	% Sub	Type of Work	% Dir	% Sub
Airport Work			Excavation			Plumbing		
Blasting			HVAC			Roofing		
Bridge Const			Grading			Sign Installation		
Carpentry			Insulation			Sewer		
Concrete			Maintenance			Steel/ Structure		
Demolition			Masonry			Steel/Ornam.		
Drilling			Mechanical			Steel/ Road		
Drywall			Painting			Supervise Only		
Electrical			Plastering			Water Gas Main		
Other (describe)								

If subco	ontractor exposure 1	s present, are Certifi	cates of Insurance m	aintained fo	or the Wor	kers Comp	o coverage?	
	Yes	No						
		ted will be picked up	at audit by the carrie	er)				
Does ap	oplicant have a form	nal safety program in	corporated in operation	ions?				
	Yes	No						
a.		clude the incorporation						
		Meeting(s), documer	nted?	YES	NO			
		spection Program?		YES	NO			
	Formal Lift Prote			YES	NO			
	Formal Fall Prote			YES	NO			
	Pre Hire Drug Te			YES	NO			
	Post Accident Dru		10	YES	NO			
	Second Injury Qu	estionnaire Complete	ed?	YES	NO			
b.	If No to the above Yes	e, is applicant willing No	to implement safegu	ards into p	rogram?			
		er 15' or 2 stories in h			No			
(1f yes,	please explain – inc	clude percentage of v	vork at or above heig	(ht.)				
	a. How is work	performed at increas	ed height levels? (la	dder, scaffo	olding, etc.	.)		
		y type of roofing ope clude total percent of		Yes		_No		
Does ap	oplicant perform an	y work outside of sta	te shown as address	on Page 1?		Yes	No	
(if yes,	list all states travele	ed)						
Does th	e insured have emp	bloyment exposure su	bject to USL&H or .	Jones Act?		Yes	No	
(if yes,	please explain)							
Are em	ployees allowed to	operate applicant's v	vehicle(s) / equipmen	t?	Yes		No	
	a. If yes, are MVI	Rs reviewed on a reg	ular basis?	Yes		No		
	·	naximum allowable v						
Is any i	nterior framing wor	k performed?	Yes	No	C			
determina his knowl may be is	ation of insurability. The ledge, information and b sued and will become part ed by Loss Control Surv	upplemental Application i e undersigned, therefore w welief. The supplemental a art of such policy. A signa ey required by Carrier. A	varrants that the information pplication and the application and the application and the application and the application of the provided on complexity of the provided on the	on contained h ation to which leted form at t	nerein (consi it is appende he time of bi	sting of two p ed, shall be th nding and wi	pages) is true and a le basis of any insu ll be subject to ver	accurate to the best of irrance policy that diffication as
Signatu	re of Applicant*							
*must b	be completed by an	owner, officer or aut	horized representativ	/e				
Name &	& Title of Above							
Date								