National Casualty Company

Home Office
Madison, Wisconsin
Administrative Office
8877 North Gainey Center Drive • Scottsdale, Arizona 85258
1-800-423-7675

PERSONNEL CONSULTANTS AND TEMPORARY HELP SERVICES PROFESSIONAL LIABILITY AND EMPLOYMENT PRACTICES LIABILITY

GENERAL LIABILITY SUPPLEMENTAL APPLICATION

APPLICANT'S INSTRUCTIONS:

1. Complete this form to apply for General Liability Coverage.
2. If space is insufficient to answer any question, use the reverse side or attach a separate sheet. Answer all questions.

PLEASE NOTE: The Limits of Liability for The General Liability Coverage Part will be separate Limits of Liability; however, the General Liability Limits of Liability must be equal to the Limits of Liability selected for the Professional Liability Coverage Part.

(PLEASE TYPE OR PRINT)

1. Name of Applicant: ____

2. General Liability Deductible desired:
   ❑ $0 ❑ $2,500 ❑ $5,000 ❑ $7,500 ❑ $10,000 ❑ $25,000 ❑ $50,000
   ❑ Other than above, indicate amount: $______________________________
   MAXIMUM DEDUCTIBLE WILL BE DETERMINED AFTER UNDERWRITING REVIEW.

3. Complete the following chart for any owned or leased premises (use a separate sheet of paper if needed):

LOCATION ADDRESS	OCCUPANCY	SQUARE FOOTAGE	AGE OF BUILDING	IF > 25 YRS, HAS PLUMBING/WIRE BEEN UPDATED IN THE PAST FIVE (5) YEARS?
	❑ Owned ❑ Leased			
	❑ Owned ❑ Leased			
	❑ Owned ❑ Leased			

4. Is prior related experience required of your employees? .... ❑ Yes ❑ No
5. Do you perform background screening? .... ❑ Yes ❑ No
6. Do you have a formal classroom training program in operation? .... ❑ Yes ❑ No
7. Do you have an on-the-job training program established? .... ❑ Yes ❑ No
8. How many years have you been in operation? _________ If new, number of years related experience: __________
9. Do you have a formal safety program in operation? .... ❑ Yes ❑ No
10. Do you have medical facilities on premises? .... ❑ Yes ❑ No
11. Are medical facilities accessible within ten (10) minutes? .... ❑ Yes ❑ No

12. ADDITIONAL COVERAGES DESIRED:

- ❑ Employee Benefits Liability Coverage (Claims Made). Limit desired? $____________________
  (same as GL or less)

  Do you currently carry Employee Benefits Liability Coverage? .... ❑ Yes ❑ No

  If so, what is the retroactive date? ____________________
- ❑ Hired & Non Owned Auto. Limits desired? $____________________
  (same as GL or less / maximum of $1,000,000)

  If requested, please complete the Hired & Nonowned Automobile Supplement.
- ❑ Personal Property of Others In Your Care, Custody or Control
- ❑ Increase in Medical Payments to $10,000 from $5,000.
- ❑ Additional Insureds (if so, complete question 13. below)
- ❑ Waiver of transfer of rights of recovery (if so, complete question 14. below)
- ❑ Employers Liability / Stop Gap Coverage (applicable in ND, OH or WA only).

  If requested, please indicate Total Company Payroll $____________________

  Check box for Limit desired:
  - ❑ $250,000 Bodily Injury by Accident—**Each Accident**/
    $250,000 Bodily Injury by Disease—**Each Employee**/
    $500,000 **Aggregate**
  - ❑ $500,000 Bodily Injury by Accident—**Each Accident**/
    $500,000 Bodily Injury by Disease—**Each Employee**/
    $500,000 **Aggregate**
  - ❑ $1,000,000 Bodily Injury by Accident—**Each Accident**/
    $1,000,000 Bodily Injury by Disease—**Each Employee**/
    $1,000,000 **Aggregate**

13. Are you required to name any other business or person as an additional insured? .... ❑ Yes ❑ No

(If yes, please list name and address of each and state interest. Use separate sheet if required.)

NAME	ADDRESS	INTEREST

14. Are you required to waive your subrogation right against an other business or person? .... ❑ Yes ❑ No

(If yes, please list name and address of each and state interest. Use separate sheet if required.)

NAME	ADDRESS	INTEREST

15. Does the Applicant place their employee(s) in a position which requires the employee(s) to operate:

- ❑ Forklifts
- ❑ Fixed machinery at site
- ❑ Mobile Equipment (Floor Sweepers, mowers, etc.)
- ❑ Earth moving equipment (bulldozers, graders, etc.)
- ❑ Cranes
- ❑ Aircraft or watercraft

16. Does the applicant require temporary employees to be OSHA certified in equipment operation prior to job placement? .... ❑ Yes ❑ No

    If "No," Explain: ____________________

17. Do you require an agreement from the client which holds you harmless for any responsibility for claims resulting form the operation of the above-mentioned equipment referred to in Question 15.? .... ❑ Yes ❑ No

18. Is general liability coverage currently in force? .... ❑ Yes ❑ No

    If "Yes," please provide:

    Insurance Company: ____________________

    Expiration date: ____________________ Limit of Liability: ____________________

    Premium: ____________________ Deductible: ____________________

    Is the policy: ❑ Claims Made? ❑ Occurrence?

CLAIM HISTORY:

19. Have there been any General Liability claims or incidents made against you, any employee or former employee, the Applicant or anyone proposed for this insurance, in the last five (5) years? .... ❑ Yes ❑ No

    If "Yes," how many? ____________________

    If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each claim.

20. Are you or anyone proposed for this insurance aware of any circumstances which might give rise to a General Liability claim or incident? .... ❑ Yes ❑ No

    If "Yes," how many? ____________________

    If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

21. Was prior General Liability coverage ever cancelled or nonrenewed (OTHER THAN BEING NONRENEWED DUE TO THE CARRIER NO LONGER WRITING THESE COVERAGES) (Not Applicable to Missouri Applicants)? .... ❑ Yes ❑ No

    IF "YES," PLEASE EXPLAIN REASON FOR NONRENEWAL OR CANCELLATION:

    ____

    ____

22. Have there been any incidents or claims made against you, any employee or former employee, the Applicant or anyone proposed for this insurance, in the last five (5) years involving any of the following additional coverage you are requesting from Question 12., above? .... ❑ Yes ❑ No

    ❑ **Employee Benefits Liability**

    ❑ **Hired & Non Owned Auto Liability**

    ❑ **Liability for the personal property of others in your care, custody or control**

    ❑ **Medical expenses for others**

    ❑ **Additional Insureds**

    ❑ **Waiver of transfer of your rights of recovery against others**

    ❑ **Employers Liability/Stop Gap (applicable in ND, OH or WA only)**

    If "Yes," how many? ____________________

    If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each claim.

SIGNATURE SECTION AND OTHER INFORMATION:

NOTE: Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE APPLICANT UNDERSTANDS AND AGREES THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other 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.

FRAUD WARNING (Applicable in Tennessee and Washington): It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other 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 be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for the violation.

____
Name of Applicant

____ _____________________________
Signature and Title of Principal (must be owner, partner or officer) Date

____
Print Name and Title of Principal Signing Above

Agent Name: ____________________________________ Agent License Number: __________________
(Applicable to Florida Agents Only)

Iowa Licensed Agent: ____
(Applicable to Iowa Agents Only)