Omega Insurance Solutions

Workers Compensation
Janitorial Supplemental Application

Company Name:___________________________________
Company Website:_________________________________

Description of operations

1. % of residential homes cleaning :_______________
2. How many homes do they clean per day? ______
3. % of commercial janitorial cleaning:__________ (How many cleaned per day?______)
   Office:__________ Industrial%___________
   Construction%___________ Medical hospital/Nursing homes%___________
4. How many full time employees? Part time? If part time employees- do they work anywhere else?
5. Does insured utilize any 1099 employees? yes ☐ no ☐ (if yes, what %_____ Are they insured? ____)
6. Does insured conduct any hazard material removal/clean-up?
7. Does insured conduct parking lot sweeps?
7. Does insured do any mold remediation or disaster restoration work?

Employee Information:

1. Does the insured provide Medical Benefits? yes ☐ no ☐
   Percentage employer pays: ___% Percentage employee's participating: __%
2. Is sick time provided? yes ☐ no ☐
3. Is vacation time provided? yes ☐ no ☐
4. Percentage of annual turnover? ___________%
5. Does insured take applications for potential employees? yes ☐ no ☐
6. Does insured check potential employee references? yes ☐ no ☐
7. Does insured require pre-hire physicals? yes ☐ no ☐
8. Does insured require pre-hire drug testing or post hire drug testing? yes ☐ no ☐
9. Any exterior window washing above ground? yes ☐ no ☐
10. Does the risk conduct any hazard material removal/clean-up? yes ☐ no ☐
11. Does the risk conduct any construction or bank-owned or clean-up? yes ☐ no ☐
12. Does the risk conduct parking lot sweeps? yes ☐ no ☐
13. Does the risk conduct any exterior pressure cleaning wall or rooftop yes ☐ no ☐
14. Any Residential cleaning? yes ☐ no ☐

Company Operated Vehicles: *If more than 4 drivers and vehicles, please provide a vehicle list and age of the drivers.*

1. Number of facilities per day?_________
2. Number of drivers: _______________ vs. total number of employees ________
3. Number of employees in same vehicle________ Radius of operations:____________________
4. Are motor vehicle records checked? yes ☐ no ☐ Number of Autos:___________
   If no company operated vehicles,
   a. How many employees travel together______________
   b. Are MVR's checked for all drivers? yes ☐ no ☐

Safety Organization Information:

1. Does insured have an active safety program? yes ☐ no ☐
2. Documented safety meetings with all employees? yes ☐ no ☐
   How often? ________
3. Does insured have an Early return to work program? yes ☐ no ☐
4. Does insured have an employee training program? yes ☐ no ☐
   If so, types of training done: ____
5. Does insured have a safety incentive program? yes ☐ no ☐
6. Require use of protective equipment? yes ☐ no ☐
   What type?

The applicant warrants and represents to the insurer that the information entered in this supplemental application is true and correct. The applicant acknowledges that the information presented herein is material to the decision of the insurance company to issue a policy, and that this issuance of a policy by the insurer is in reliance upon the sufficiency and accuracy of the information by the applicant in this supplemental application. **MUST BE SIGNED TO BIND**.

Authorized Representative: ____
Print Name

Signature:____Date:_____________