



## *Supplemental Underwriting Application United States Longshoremen & Harbor Workers Act*

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

1. Describe the insureds hiring and screening process.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What type of training program does the insured have for new employees and to what extent are supervisors involved?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does the insured have a formal Return to work program? \_\_\_\_ yes \_\_\_\_ no

4. Does the insured have a Substance Abuse Screening Program? \_\_\_\_ yes \_\_\_\_ no

Pre hire \_\_\_\_ yes \_\_\_\_ no

Random \_\_\_\_ yes \_\_\_\_ no

Post accident \_\_\_\_ yes \_\_\_\_ no

5. Does the insured have a formal written safety program? \_\_\_\_\_ yes \_\_\_\_\_ no  
If so, are supervisors and employees held accountable for following the program?  
\_\_\_\_\_ yes \_\_\_\_\_ no

If answer to either is no, please explain why.

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6. Is management committed to safety and portrays a positive attitude and will work with our Loss Control Consultants complying with recommendations to create a safe work place? \_\_\_\_\_ yes \_\_\_\_\_ no

7. List the employer paid benefits & those the employee may participate in:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

8. What is the average turnover rate for employees? \_\_\_\_\_ / year  
Managers & Supervisors? \_\_\_\_\_ / year

9. What is the average employee tenure \_\_\_\_\_ , age range \_\_\_\_\_ , and experience level \_\_\_\_\_ ?

10. Number of full time employees \_\_\_\_\_  
Number of part-time / seasonal employees \_\_\_\_\_

11. How would you describe the overall employee relations at this company?

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12. Are the employees Union \_\_\_\_\_ or Non-union \_\_\_\_\_?

13. Any critical events such as change of ownership, management turnover, reorganization, layoffs, bankruptcy etc. in the last three years? If so, please describe the applicable details.

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14. Has the company had any loss control services performed in the last three years?

Yes \_\_\_\_ No \_\_\_\_

If so, have they complied with all recommendations? Yes \_\_\_\_ No \_\_\_\_

List any recommendations / changes they have made in their safety program that would improve their overall safety results:

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Prospect / Insured \_\_\_\_\_

Effective date of coverage \_\_\_\_\_

Form Completed by \_\_\_\_\_

Agency Name \_\_\_\_\_