NORMANDY INSURANCE COMPANY

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 the insured utilize any 1099 employees? yes no (if yes, what %_____ Are they insured? ____)
6. Does the risk conduct any hazard material removal/clean-up?
7. Does the risk conduct parking lot sweeps?

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:_____