1111 W. San Marnan Drive
P.O. BOX 1328
WATERLOO, IA 50704
PHONE: 800-362-3363 FAX: 319-235-6656
EMAIL: info@vgminsurance.com

SUPPLEMENTAL APPLICATION

VGM MEMBER No. _____ **Proposed Effective Date** _____

LEGAL NAMED INSURED (full name of all companies to be insured under this policy)

_____

DBA _____

Entity is: ◯ S Corporation ◯ C Corporation ◯ Individual ◯ Partnership ◯ Limited Partnership ◯ LLC ◯ Other

Website _____

Mailing Address _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

Contact Person _____ Email _____

Phone No. _____ Fax No. _____

FEIN _____ Medicare Provider No. _____

Do you have any bankruptcies, tax or credit liens against you? ◯ Yes ◯ No

APPLICATION FOR PROPERTY

☐ Check box to decline coverage

Location No. _____ Physical Address _____

◯ Main ◯ Retail ◯ Storage

Burglar Alarms: ☐ Central ☐ Local ☐ None Sprinklers: ◯ Yes ◯ No

Fire Alarms: ☐ Central ☐ Local ☐ None Miles from Fire Dept. _____

Fire Hydrant Available: ◯ Yes ◯ No

Year Built _____ Square Feet You Occupy _____

Total Square Feet of Building _____ Number of Stories _____

Building Owner _____

Address _____

List other occupants of building and type of business performed _____

_____

Last update: Plumbing/Year _____ Wiring/Year _____ Roof/Year _____ AC/Heat/Year _____

Contents Coverage Desired $ _____ Revenue Per Location _____

Building Coverage Desired $ _____ BI Coverage Desired $ _____

Deductible Options: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Construction Types: ☐ Frame ☐ Joisted Masonry ☐ Noncombustible ☐ Masonry Noncombustible

Make a copy of this page for additional locations.

Current Carrier(s) and Premium _____

Have you had any property claims during the past five years? ◯ Yes ◯ No ◯ N/A

***If yes, please provide a copy of your loss runs for the past five years.**

Has your coverage been canceled/non-renewed in the past three years? ◯ Yes ◯ No ◯ N/A

(respond only if state law permits)

If yes, please explain _____

Optional Coverages

Do you want earthquake coverage? ◯ Yes ◯ No

Do you want wind/hail coverage? ◯ Yes ◯ No

Do you want flood coverage? ◯ Yes ◯ No

Are you located within 10 miles of a coast? ◯ Yes ◯ No

Supplemental Application for Property

Transit Exposure (complete if applicable)

1. Please identify if property is being shipped via FedEx®, UPS® or any other third-party carrier _____
   If so, what are the annual number of shipments? _____
2. Please provide the maximum amount of property in transit in any one shipment _____
3. Does the third party carrier provide primary coverage on the shipment in the event of a transit loss? _____
4. Do you transport any property? _____ If so, what is the maximum amount in any one vehicle? _____

Off-Premises Exposure (complete if applicable)

1. Is property being stored at any location not listed on the application? If so, please provide approximate amount
   _____
2. Does the property remain in the possession of a salesman/company employee overnight? If so, please provide approximate amount _____
3. How much equipment do you have in transit at any given time? _____
   _____

Pharmacy Exposures (complete if applicable)

1. What are the average and maximum values of the prescription drug supply?
   Average _____ Maximum _____
2. How long would it take to replace an inventory of pharmaceuticals? _____
3. How is the store secured? _____
4. How is the prescription drug department secured? _____
5. How is access limited to the prescription filling and pharmaceutical storage areas? _____

Signature_____ **Date**_____/_____/_____

APPLICATION FOR BUSINESS AUTO ☐ Check box to decline coverage

Please attach schedule of drivers and vehicle information or fill out the tables below.

Liability Limit: ☐ $1,000,000 ☐ $500,000

Uninsured/Under-insured Motorist: Will Match Selected Liability Limits

Uninsured Motorist Property Damage ◯ Yes ◯ No (Not available in all states)

Med Pay: $5,000 PIP: Basic (Not available in all states)

Radius of Operations: (Distance one way in miles) ◯ <50 ◯ 50-200 ◯ 200+

DRIVER INFORMATION

Driver's Name	Birth Date	License Number	State	M/F

VEHICLE/AUTO INFORMATION

Auto Use: D = Delivery S = Salesperson P = Pleasure Use

Deductibles: Please circle which deductible option you desire.

Year, Make, Model	VIN Number	Garaged Location ZIP	Auto Use	Cost New	Comp. Deductible	Collision Deductible	Leased	Owned
					$500 $1,000 NA	$500 $1,000 NA	◯	◯
					$500 $1,000 NA	$500 $1,000 NA	◯	◯

Current Carrier(s) and Premium _____

If there are loans on any vehicles and evidence of insurance is required by the lender, please provide us with the names, mailing addresses and loan number as an attachment.

Have you had any auto claims during the past five years? ◯ Yes ◯ No

***If yes, please provide a copy of your loss runs for the past five years.**

Has your coverage been canceled/non-renewed in the past three years? ◯ Yes ◯ No ◯ N/A

(respond only if state law permits)

If yes, please explain _____

Supplemental Questions to Automobile Application

1. Are any of the vehicles listed not solely owned by and registered to the applicant? ◯ Yes ◯ No

   If yes, please explain: _____

2. Do any employees use their personal autos in the business? ◯ Yes ◯ No

   If yes, are they required to carry a minimum liability limit of $500,000? ◯ Yes ◯ No

3. Please identify any vehicles that have special equipment such as lifts and the value of this equipment

   _____

4. Does the applicant obtain motor vehicle records for employees who drive for business purposes? ◯ Yes ◯ No
5. Any vehicles owned by business but not scheduled on this application? ◯ Yes ◯ No
6. Are vehicles used for personal use? ◯ Yes ◯ No

   If so, do you have a Personal Automobile Use Policy? ◯ Yes ◯ No

7. Any vehicles used by family members for personal use? ◯ Yes ◯ No

   If yes, please provide the name, date of birth, license number and vehicle used

   _____

8. Does applicant transport oxygen tanks? ◯ Yes ◯ No

   If yes, please list the type of tanks delivered on an average per vehicle per day _____

   _____

9. Please explain the procedures in place regarding the securement of the oxygen tanks/containers while being transported _____
10. Are any state or federal filings required? ◯ Yes ◯ No

    If yes, what type? _____

11. Has any employee who will drive a vehicle in the course of employment had a moving violation in the past three years? ◯ Yes ◯ No

    If yes, list the number of drivers with violations and the number of moving violations per driver

    _____

12. Has any employee who will drive a vehicle in the course of employment had a major violation in the past three years whether work related or not? ◯ Yes ◯ No

    Please explain _____

13. Has any employee been involved in an at-fault accident in the past three years? ◯ Yes ◯ No

    If yes, list the number of drivers with accidents and the number of accidents per driver _____

14. Do you wish to have any of the following coverages?

    Towing ◯ Yes ◯ No

    Rental Reimbursement ◯ Yes ◯ No

15. Indicate which safety/risk control measures are in place:

    ☐ Driver training provided to all drivers upon start date

    ☐ Seat belt policy

    ☐ Calling and/or text messaging policy

    ☐ Vehicle maintenance program

Signature_____ **Date**_____/_____/_____

APPLICATION FOR WORKERS' COMPENSATION ☐ Check box to decline coverage

Limits Requested: ☐ $100K/$500K/$100K ☐ $500K/$500K/$500K ☐ $1Mil/$1Mil/$1Mil

Do officers want to be included in workers' compensation insurance? ◯ Yes ◯ No

With regard to sole proprietorships and partnerships, does the owner(s) want to be included in workers' compensation insurance? ◯ Yes ◯ No

Employee Class Code Breakdown **Location** _____

Class Code*	Job Description	Estimated Payroll	No. Full-time Employees	No. Part-time Employees
8017/8010	Store: Retail Sales			
8810	Clerical (No customer contact, e.g. bookkeeper)			
8742	Salespersons - Outside			
7380	Drivers/Delivery			
8835	Physicians/Clerical			
4693	Prosthetics Mfg.			
4611	Pharmacists - Drug Compounding or Blending			

**If the above class codes are not applicable to your state, the codes will be revised by our office accordingly.*

Current Carrier(s) and Premium _____

What is your current experience modification number? _____

Please attach your experience modification worksheet (page in your current policy).

Have you had any work comp claims during the past five years? ◯ Yes ◯ No

***If yes, please provide a copy of your loss runs for the past five years.**

Has your coverage been canceled/non-renewed in the past three years? ◯ Yes ◯ No ◯ N/A

(respond only if state law permits)

If yes, please explain _____

Owner/Officer Information

Owner/Officer Name	Title/Relationship	Percent of Ownership	Duties	Annual Payroll

Make a copy of this page for additional locations.

Supplemental Questions to Workers' Compensation Application

1. Are subcontractors used? ○ Yes ○ No

   If subcontractors are used, you are required to obtain and file certificates of insurance from each subcontractor.
2. Are employee health plans provided? ○ Yes ○ No
3. Do you lease employees to or from other employers? ○ Yes ○ No
4. Do you have past, present or discontinued operations involving storing, treating, discharging, applying, disposing or transporting of hazardous material? ○ Yes ○ No
5. Any prior coverage declined/canceled/non-renewed in the last three years? ○ Yes ○ No

   If yes, please explain _____
6. Does applicant own, operate or lease aircraft/watercraft? ○ Yes ○ No
7. Are employees trained in what procedures to follow during and after a robbery? ○ Yes ○ No
8. Are there established "buddy" procedures for opening and closing the business? ○ Yes ○ No
9. Are the employees advised to observe and report suspicious persons? ○ Yes ○ No
10. Do any employees drive out of state? ○ Yes ○ No
11. What is the maximum radius of operations? _____miles
12. Approximately how many drivers do you have? _____And number of owned autos not including trailers? _____
13. What is the maximum weight manually lifted?_____lbs.

    If greater than 40 lbs., what types of supplemental lifting devices are used?_____

Signature_____ **Date**_____/_____/_____