



ASA

Agri-Services Agency
Leaders in Agricultural Insurance

AGRI-SERVICES AGENCY GROUP

Landscaping Supplemental Application

Company Name:			
Contact Name:			
Address:			
City:	State:	Zip:	FEIN#:
Phone #:	Cell Phone #:	Fax#:	
Website and/or Email Address:			

1. Have you had previous Workers' Compensation coverage? Yes No
 Have you ever been cancelled? Yes No
 If yes, explain: _____

2. Has any employee been injured while working for a previous employer? Yes No
 If yes, give full details: _____

3. Please indicate which one(s) apply to your business:

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, how much	%
Lawn maintenance	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much	%
Landscaping installation / construction	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much	%
Nursery	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much	%
Tree Pruning	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much	%
Excavating	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much	%
Snowplowing	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much	%
Gravel Pit Work	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much	%

4. Please give a detailed description of your entire operation:

5. Do you do any type of spraying or chemical application? Yes No
 If yes, is a license required to apply these sprays/chemicals? Yes No
 If a license is required, what type of training is provided to employees who do the work?

6. Do you provide safety equipment for your employees (eye protection, gloves, etc)? Yes No
If yes, give full details: _____

7. Do you have a safety program? Yes No
Please describe: _____

8. Please list any mobile or heavy equipment used by employees:
Type of Equipment Year

9. Is there a proper machine guarding in place on all machinery? Yes No

10. Who maintains/repairs machinery? _____

11. Please provide a list of all employees, their date of birth & license #s for those having **any** access to driving company vehicles or use their own personal vehicles for work: (attach additional page if necessary)

Name of Driver	Date of Birth	License #	State Issued

12. Do employees report to work directly at job sites or do they meet at place of employment and travel to job sites in groups? _____

13. Do you employ subcontractors, owner-operators, and/or independent contractors? Yes No
If yes, do you maintain a file of certificates of insurance for each Yes No

Requested date of coverage: _____

- A. *Coverage will become effective at 12:01 a.m. on the date stated above, subject to approval of this application and receipt of the deposit premium in our office. Signing of this application warrants that all of the above questions have been completely answered and have not been willfully misrepresented in order to obtain insurance with the Agri-Services Safety Group.*

- B. *The premium quoted will be based upon the nature of the operations and the estimated payroll disclosed by the employer in this application. The employer shall furnish the Agri-Services Safety Group with proper notice of any change in the nature of its operations or its estimated payroll; such changes may result in an increase or a decrease in the premium due under this policy. The employer agrees to keep an accurate record of employees and payroll expenditures, and to report injuries and occupational diseases to the Safety Group immediately.*

ALL INFORMATION SUPPLIED BY THE APPLICANT IS SUBJECT TO VERIFICATION

THE APPLICATION **MUST BE SIGNED** BY AN OWNER, A PARTNER, OR A CORPORATE OFFICER.

Signature: _____

Title: _____

Date: _____

Print Name of Signature: _____

AGENT SIGNATURE: _____