



# 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:** \_\_\_\_\_