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:

Lawn maintenance	❒ Yes	❒ No	If yes, how much	%
Landscaping installation / construction	❒ Yes	❒ No	If yes, how much	%
Nursery	❒ Yes	❒ No	If yes, how much	%
Tree Pruning	❒ Yes	❒ No	If yes, how much	%
Excavating	❒ Yes	❒ No	If yes, how much	%
Snowplowing	❒ Yes	❒ No	If yes, how much	%
Gravel Pit Work	❒ Yes	❒ No	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: _____