Cannabis Supplemental

Field	Option 1	Option 2	Option 3	Option 4
Named Insured:				
Website:				
Detailed Description of Operations:				
Hours of Operation:				
Operations Include (check all that apply):	☐ Dispensary	☐ Growing	☐ Processing	☐ Delivery
Employees (# of Each):	☐ Full Time	☐ Part Time	☐ Seasonal	☐ Volunteers
How are Employees Paid:	☐ Hourly	☐ Commission	☐ Salary	**Other:**
Benefits Offered (check all that apply):	☐ Paid Sick Time	☐ Paid Vacation	☐ 401k	☐ Retirement
Group Health Coverage:	☐ Yes	☐ No	**If yes, % paid by employer:**	☐ %
Pre Hire (check all that apply):	☐ Written Application	☐ Reference Checks	☐ Physicals	
	☐ Pre-Hire Drug Testing	☐ Random Drug Testing	☐ Post Accident Drug Testing	
	☐ Pre-Hire MVR Checks	☐ Annual MVR Checks	☐ Criminal Background Checks	
	Other, please list:			
Return-To-Work/Light Duty Available:	☐ Formal/Written	☐ Informal/Verbal	☐ None	
Subcontractors Used:	☐ Yes	☐ No	**If yes, what % of payroll:**	☐ %
Are COIs Obtained for Subs:	☐ Yes	☐ No	☐ N/A	
Employee Average Annual Turnover:	☐ %			
Day Laborers or Employee Leasing:	☐ Yes	☐ No		
Safety Program in Place:	☐ Formal/Written	☐ Informal/Verbal	☐ None	
Safety Training:	☐ Yes, Documented	☐ Yes, Verbal	☐ None	
Safety Meetings:	☐ Yes	☐ No		
If yes, frequency:	☐ Weekly	☐ Monthly	☐ Quarterly	☐ Annually
MSDS Program	☐ Yes	☐ No		
Chemicals Used: (herbicides/pesticides)	**Please List:**			☐ N/A
Respiratory Program in Place:	☐ Yes	☐ No		
Building Properly Ventilated:	☐ Yes	☐ No		
Lifting Exposures:	☐ <25lbs	☐ 25-40lbs	☐ 40+lbs	☐ N/A
Machinery Guarded & Maintained:	☐ Yes	☐ No	☐ N/A	
Lockout/Tagout:	☐ Yes	☐ No	☐ N/A	
Forklifts Used:	☐ No	☐ Yes	☐ **Check Box if Operators Are Annually Certified**	
Maximum Height in Feet:	☐ 0-6 Feet	☐ 7-15 Feet	☐ 15 Feet and Above	☐ N/A
If heights, what is used:	☐ Scissor Lift	☐ Scaffolding	☐ Bucket Truck	☐ Ladder
	Other, please describe:			
Type(s) of Fall Protection:	☐ Fall Arrest	☐ Positioning	☐ Retrieval	☐ Suspension
Provide details regarding what the insured has implemented to keep employees safe in response to COVID19:				
	Other, please list:			
List all Personal Protective Equipment:	☐ Gloves	☐ Back Belts	☐ Protective Clothing	☐ Ear Plugs
	☐ Goggles	☐ Non-Slip Shoes	☐ Steel Toed Boots	☐ Masks
	☐ Hard Hats	**Other, please list:**		
Driving or Delivery Mileage **%** of Each:	☐ <50	☐ 50-100	☐ 100+	☐ N/A
Group Transportation:	☐ No	☐ Yes	**If yes, # of Employees:**	☐ #
Are Vehicles Company Owned:	☐ No	☐ Yes	☐ **Check Box if Owned Vehicles are Unmarked**	
Vehicle Maintenance Program:	☐ In-House	☐ Outside Vendor	☐ No	
Distracted Driving policy in place:	☐ No	☐ Yes	☐ N/A	
Drivers Training:	☐ No	☐ Yes	☐ N/A	
CDL's Required:	☐ Yes	☐ No	☐ N/A	
Overnight Travel by Employees:	☐ No	☐ Yes	**If yes, frequency:**	
Average Distance Driven Per Day:	☐ Minimum	☐ Maximum	☐ N/A	
Average # of Deliveries Per Day:	☐ Minimum	☐ Maximum	☐ N/A	
If Out of State Transport, List States:				
Security Systems Used (check all that apply):	☐ Interior Camera(s)	☐ Metal Detector		☐ Panic Button
	☐ Exterior Camera(s)	☐ Central Station Burglar Alarm		☐ Metal Doors
	☐ Gated Doors	☐ Central Station Fire Alarm		☐ Door Intercom
	☐ Gated Windows	☐ Security Vestibule/Mantrap		
	Other Security:			
Written Security Plan (including what to do in the event of robbery):	☐ Yes	☐ No		
Security Guards:	☐ Insured's Employees	☐ Outside Security Firm Personnel		☐ N/A
Security Guards Armed:	☐ Yes	☐ No	☐ N/A	
Outside Security Company Used:	☐ Check Box if COI's are Obtained	☐ Check Box if Insured is named as an Additional Insured on Security Company's GL Policy		
Please Describe Extraction Process in Detail:				
Extraction Training Provided:	☐ Yes	☐ No	☐ N/A	
Emergency Plan in Place in case of toxicity, fire,	☐ Yes	☐ No	☐ N/A	
Square footage of Grow Area:				
Flow Meters or Water Timers Used:	☐ Yes	☐ No		

Affirmation

The undersigned acknowledges and understands the information provided herein will be used to evaluate the applicant and a decision as to whether the applied to insurance company will offer workers' compensation insurance will be made, in part, based on the information provided. Signature below indicates the information provided is true and correct. This Supplemental Application must be signed by a principle, owner or partner of the entity applying for insurance.

Owner/Officer Signature: ______________________ **Date:** ______________