



Shooting Sports Work Comp Supplemental

Section I. General Information	
Company Name:	
Federal Tax ID Number:	
Business Type: Corp <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> LLC <input type="checkbox"/> Other <input type="checkbox"/>	
Insured's Website:	
Please provide a detailed description of operations:	
Number of years in business:	
Member of a trade group or association:	
Describe complete operations of Insured:	
Have there been any incidents in which police or law enforcement were involved in the last 5 years: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe in complete detail:	
Has this Applicant been in business for 3 or more years? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has the Applicant had continuous WC coverage over the past 3 years? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the Senior Officer, Partner, or Proprietor have 3 or more years experience in this type of business? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is there more than one entity to be covered? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe:	
Does the Applicant operate in more than one state? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, list each state and operation:	
Does the Applicant obtain proof of insurance coverage for any subcontractors utilized? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the Applicant have exposure insured by any Assigned Risk Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the Applicant in Chapter 11 Bankruptcy proceedings? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the Applicant own, operate or lease any aircraft for business purpose? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section II. Operations	
Hours of Operation: _____ to _____ Number of days per week:	
Are the insured's operations seasonal: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please explain:	
Number of employees: Full time: _____ Part time: _____ Seasonal: _____	
Employee turnover is: Low <input type="checkbox"/> Average <input type="checkbox"/> High <input type="checkbox"/>	
What is the hourly wage of the governing class of employee:	
Do employees utilize any safety protection: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe:	
Does the insured engage in the sales of firearms: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe:	
Is the insured fully accredited and licensed to sell firearms in their state: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe:	
If firearms are sold, what percentage of revenue does it account for: _____ %	
Total revenue for the insured:	
Are any automatic weapons or military grade weapons sold and/or rented to the public: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are Range Masters present for all people shooting automatic weapons: Yes <input type="checkbox"/> No <input type="checkbox"/>	

If yes, please describe:
Are all employees trained in firearm safety: Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe the safety and training required:
Are any owners/employees licensed to carry firearms at work: Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe:
Does the insured provide gunsmithing services: Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, # of gunsmiths:
Total payroll for gunsmithing:
If yes, please describe activities of gunsmith:
Does the insured engage in reloading of ammunition: Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, who is responsible and what safety training and equipment is provided to prevent injury?
Does the insured use, store, sell or manufacture black powder in the course of their business? Yes <input type="checkbox"/> No <input type="checkbox"/>
Please describe the storage and handling of ammunition:
Does the applicant arrange any combat simulation courses? Yes <input type="checkbox"/> No <input type="checkbox"/>

Section III. Range Operations	
Type of Range:	Firearms <input type="checkbox"/> Archery <input type="checkbox"/> Both <input type="checkbox"/> Other <input type="checkbox"/>
Indoor Range:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, # of lanes:	
Outdoor Range:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, # of lanes/stations:	
Are there trap, skeet and sporting clays stations:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, # of stations:	
Maximum distance allowed/shot:	
Is club membership required?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please attach a copy of the membership contract.	
What is the minimum age requirement to shoot?	
Is a Range Master with a minor who is shooting?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are all shooters required to sign liability waivers:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please attach a copy.	
Are eye and ear protection mandatory:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is a supervisor on duty at all times?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Total number of range supervisors:	
Number of range supervisors with NRA Instructor Certification:	
Are written rules of the range openly displayed:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the insured provide shooting lessons:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the range in compliance with any recognized standards (ie. NRA, NFAA, IBO, NSSF, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe:	
Are all employees exposed to injurious noise levels required and trained to use adequate hearing protection?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are any employees to injurious noise levels greater than or equal to 85 decibels on an 8-hour time-weighted average?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are any employees exposed to hazardous levels of lead dust generated when guns are fired or backdrops are cleaned?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are employees exposed to hazardous levels of lead dust provided with monitoring, respiratory protection, protective work clothing and equipment, and training?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section IV. Management	
Is owner active in business:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe duties:	
Are all owners/partners excluded under W/C policy:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are health benefits provided:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does insured have a return to work program:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Modified duty offered to injured employees:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the insured willing to implement safety recommendations made by the carrier:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the insured willing to implement loss control recommendations made by the carrier:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any incidents in which police or law enforcement have been involved in the last 5 years:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe in complete detail:	
Are employees used to clean the lead traps on the range?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does applicant utilize subcontractors to remove lead?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does applicant provide/require lead testing/monitoring for employees?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, please describe how you address lead exposure at your range?	
Has the Applicant filed for bankruptcy within the last 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain:	
Within the last 3 years, has the Applicant's workers compensation insurance been cancelled for non-payment of premium?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
If so, please describe the circumstances:	
Are any employees working from a residence for operations classed as other than 8810 (clerical) or 8742 (outside sales)?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe operations performed at the residence:	
Does the applicant provide group transportation to more than four employees in one vehicle?	
Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section V. Hiring Practices	
Complete written applications:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pathogenic test (i.e. Lead):	Yes <input type="checkbox"/> No <input type="checkbox"/>
Reference checks:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Audio testing:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Criminal background checks:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pre/post employment physicals:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Orthopedic back test:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug/substance abuse test:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are the applicant's employees provided group health insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the Applicant employ leased, alternative, temporary, volunteer, donated labor?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the Applicant employ more than 25% of the workforce as part-time or seasonal employees?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, please describe operation:	
Is the Applicant, requesting specific Alternate Employer Coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, please provide specific information, i.e. Alternate Employer Name, State of Special or Temporary Employment, Address, and Contract or Project:	
Is the applicant requesting the exclusion of Partners, Officers or others?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, please provide specific names:	
Is the applicant requesting the inclusion of Sole Proprietors, Partners, Officers, or Others?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section VI. Safety	
Person responsible for safety:	
Does insured have a specific medical provider to treat injured employees: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, select one: Clinic <input type="checkbox"/> Physician <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other <input type="checkbox"/>	
Does insured have a written safety program: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is there a formal firearm training and safety program: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is there a safety incentive program in place: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are there safety meetings conducted for all employees: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, how often:	
Equipment safeguards utilized: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe:	
Equipment inspection/maintenance program: Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please describe:	
Slip and fall prevention program: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hazardous materials communication program in place: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Violence intervention program: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Drug and alcohol awareness program: Yes <input type="checkbox"/> No <input type="checkbox"/>	
First aid at jobsite: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are any employees trained in first aid: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are any employees trained in CPR: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Equipment inspection/maintenance program? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section VII. Premises	
Housekeeping/cleanliness at jobsite:	Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/>
Condition of equipment:	Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/>
Proper safeguards in place:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any cooking on premises:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe:	
Any alcohol provided:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe:	
Is the insured's operating hours past 9 p.m.?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section VIII. Broker Information	
Does this broker currently control the WC: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the current or prospective Experience Mod greater than 1.50 or less than 0.60? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the insureds loss experience over the last three years include any losses with an incurred amount over \$25,000? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does the loss frequency rate exceed 1 claim per \$10,000 in premium? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If so, please explain frequency:	
How did the broker learn about this program?	

Section IX: Premium and Payroll Information (Need Last Four Years)			
Year	Premium Info	Year	Payroll Info
Current		Current	
Previous		Previous	
Previous		Previous	
Previous		Previous	
Has the Applicant experienced an increase or decrease in payrolls greater than 40% over the last 3 years?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain:			

Applicant's Statement
I have read and completed the attached application and I declare that to the best of my know ledge and belief all of the foregoing answers statements are true, and that these answers and statements are offered as an inducement to Sage Program Underwriters to quote and issue the policy for which I am applying.
Named Applicant Signature:
Agency:
Producer's Signature: