

Shooting Sports Supplemental Application

Section I. General Information	
Company Name:	
Federal Tax ID Number:	
Business Type: Corp [] Partnership [] Individual [] LLC [] Other []	
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 [] No []	
If yes, please describe in complete detail:	
Has this Applicant been in business for 3 or more years?	Yes [] No []
Has the Applicant had continuous WC coverage over the past 3 years?	Yes [] No []
Does the Senior Officer, Partner, or Proprietor have 3 or more years experience in this type of business?	Yes [] No []
Is there more than one entity to be covered?	Yes [] No []
If yes, please describe:	
Does the Applicant operate in more than one state? Yes [] No []	
If yes, list each state and operation:	
Does the Applicant obtain proof of insurance coverage for any subcontractors utilized? Yes [] No []	
Does the Applicant have exposure insured by any Assigned Risk Plan? Yes [] No []	
Is the Applicant in Chapter 11 Bankruptcy proceedings? Yes [] No []	
Does the Applicant own, operate or lease any aircraft for business purpose? Yes [] No []	

Section II. Operations	
Hours of Operation: _____ to _____ Number of days per week: _____	
Are the insured's operations seasonal: Yes [] No []	
If yes, please explain:	
Number of employees: Full time: _____ Part time: _____ Seasonal: _____	
Employee turnover is: Low [] Average [] High []	
What is the hourly wage of the governing class of employee:	
Do employees utilize any safety protection: Yes [] No []	
If yes, please describe:	
Does the insured engage in the sales of firearms: Yes [] No []	
If yes, please describe:	
Is the insured fully accredited and licensed to sell firearms in their state: Yes [] No []	
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 [] No []	
Are Range Masters present for all people shooting automatic weapons: Yes [] No []	

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?
Please describe the storage and handling of ammunition including black powder:
Does the applicant arrange any combat simulation courses? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the applicant engaged in any hunting or guide services? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe:

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 [] No []
If yes, please describe duties:	
Are all owners/partners excluded under W/C policy:	Yes [] No []
Are health benefits provided:	Yes [] No []
Does insured have a return to work program:	Yes [] No []
Modified duty offered to injured employees:	Yes [] No []
Is the insured willing to implement safety recommendations made by the carrier:	Yes [] No []
Is the insured willing to implement loss control recommendations made by the carrier:	Yes [] No []
Any incidents in which police or law enforcement have been involved in the last 5 years:	Yes [] No []
If yes, please describe in complete detail:	
Are employees used to clean the lead traps on the range?	Yes [] No []
Does applicant utilize subcontractors to remove lead?	Yes [] No []
Does applicant provide/require lead testing/monitoring for employees?	Yes [] No []
If no, please describe how you address lead exposure at your range?	
Has the Applicant filed for bankruptcy within the last 5 years?	Yes [] No []
If yes, please explain:	
Within the last 3 years, has the Applicant's workers compensation insurance been cancelled for non-payment of premium?	Yes [] No []
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 [] No []
If yes, please describe operations performed at the residence:	
Does the applicant provide group transportation to more than four employees in one vehicle?	Yes [] No []

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

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

Section VII. Premises	
Housekeeping/cleanliness at jobsite:	Excellent [] Good [] Poor []
Condition of equipment:	Excellent [] Good [] Poor []
Proper safeguards in place:	Yes [] No []
Any cooking on premises:	Yes [] No []
If yes, please describe:	
Any alcohol provided:	Yes [] No []
If yes, please describe:	
Is the insured's operating hours past 10 p.m.? Yes [] No []	

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

Section IX: Payroll Information			
Year	Payroll Info	Year	Premium Info
2017		2017	
2016		2016	
2015		2015	
2014		2014	
Has the Applicant experienced an increase or decrease in payrolls greater than 50% over the last 3 years? Yes [<input type="checkbox"/>] No [<input type="checkbox"/>]			
If yes, please explain:			

Applicant's Statement
I have read the attached applications and I declare that to the best of my knowledge and belief all of the foregoing statements are true, and that these statements are offered as an inducement to the Company to issue the policy for which I am applying.
Named Insured Signature: _____
Agency: _____
Producer's Signature: _____