

Janitorial Contractors Application

General Info (Complete For All Lines)

1. Name _____
(Complete name as it should appear on the policy including Inc., Corp., Ltd., Etc.)
2. Physical Address _____
No. Street City County State Zip Code
3. Mailing Address _____
No. Street City County State Zip Code
4. Insureds' Email Address _____
5. Inspection Contact _____ Phone () _____
Audit Contact _____ Phone () _____
Claims Contact _____ Phone () _____
6. Telephone () _____ Fax () _____
7. Website _____ FEIN _____
8. Date established _____ License No. _____ € Sole Proprietor € Partnership
€ Corporation € Other
9. Policy proposed effective date _____ to _____
10. Current coverage expires/expired on _____
11. Check limit of liability desired: €\$300,000 €\$500,000 €\$1,000,000 €Other _____
12. Deductible: €\$1,000 €\$2,500 €\$5,000 €Other _____
13. Total Number of:

	Full-Time	Part-Time
Employees who perform janitorial service(s)		
Owners/partners who perform janitorial service(s)		
Supervisors		

14. Please fill out the table below for the current and previous policy year:

	Current Policy Year (next 12 months)	Previous Policy Year (last 12 months)
Annual Revenue (sales)	\$	\$
Annual Payroll*	\$	\$
Amount Paid to Subs	\$	\$
Annual Billable Hours	Hrs:	Hrs:

*Employees/owners who perform janitorial services. Do not include clerical or sales payroll.

15. Indicate, in percentage totaling 100%, your customers/clients:

<input type="checkbox"/> Office Buildings	<input type="checkbox"/> Hospitals	<input type="checkbox"/> Stores
<input type="checkbox"/> Education	<input type="checkbox"/> Manufacturing Plants	<input type="checkbox"/> Nursing Homes
<input type="checkbox"/> Hotels	<input type="checkbox"/> Airports	<input type="checkbox"/> Government
<input type="checkbox"/> Medical Offices	<input type="checkbox"/> Museums	<input type="checkbox"/> Supermarkets
<input type="checkbox"/> Apartment Houses	<input type="checkbox"/> Residential Cleaning	<input type="checkbox"/> Malls
<input type="checkbox"/> Bars/Restaurants	<input type="checkbox"/> Bus/Train Stations	
<input type="checkbox"/> Other (describe) _____		

16. Indicate, in percentage totaling 100%, the services you provide:

<input type="checkbox"/> General Cleaning*	<input type="checkbox"/> Landscaping (including lawn moving)
<input type="checkbox"/> Industrial Cleaning	<input type="checkbox"/> Pest Control/Exterminating
<input type="checkbox"/> Carpet Cleaning	<input type="checkbox"/> Floor Waxing and Refinishing
<input type="checkbox"/> Ceiling Tile Cleaning	<input type="checkbox"/> Aircraft Service & Maintenance
<input type="checkbox"/> Snow Removal	<input type="checkbox"/> Maid/Housekeeping Service
<input type="checkbox"/> Elevator Maintenance	<input type="checkbox"/> Cleaning/Renovating Outside Building Walls
<input type="checkbox"/> Chimney Cleaning	<input type="checkbox"/> Building Construction or Renovation
<input type="checkbox"/> Parking Lot Operations	<input type="checkbox"/> Exterior Window Cleaning (above 1 st floor)
<input type="checkbox"/> Fire Restoration	<input type="checkbox"/> Degreasing Service (cleaning restaurant grease traps, Ansul Systems, etc)
<input type="checkbox"/> Building Security	<input type="checkbox"/> Heating/Ventilation/Air Conditioning Service
<input type="checkbox"/> Other (describe) _____	

*General Cleaning includes operations such as vacuuming, dusting, wastebasket trash pickup, floor and rug cleaning, restroom cleanup, etc.

17. If you provide exterior window cleaning, please advise the maximum number of stories: _____

18. Do you use scaffolds or rigging? € Yes € No

If yes, please answer the following:

- | | | |
|--------------------------------------|-------|------|
| • Do you own scaffolds? | € Yes | € No |
| • Do you rent scaffolds to others? | € Yes | € No |
| • Do you rent scaffolds from others? | € Yes | € No |

19. Describe other operations you perform that are not listed above: _____

20. On average, how many jobsites does a crew visit in a single shift? _____

21. For what contracts do you provide services during business hours? _____

22. Describe any service(s) that you subcontract out: _____

23. Do you obtain Certificates of Insurance from subcontractors? € Yes € No

24. Are you added as an additional insured by your subcontractors? € Yes € No

25. Describe your procedures for:

a. Prevention of Slips & Falls for workers and general public: _____

b. Use and storage of hazardous materials: _____

c. Job Site Closure (daily closing checklist): _____

d. Protection of Customer's Keys: _____

26. Please provide the names of your 5 largest clients and a brief description of services provided:

27. Supervisory Controls in Place:

- | | | |
|---|------|-----|
| a. Employees work in pairs? | €Yes | €No |
| b. Employees supervised on the job? | €Yes | €No |
| c. Single person jobs limited to experienced staff? | €Yes | €No |
| d. Periodic unannounced job site management checks? | €Yes | €No |
| e. Degree of supervision matched with job complexity and susceptibility of customers contents to theft or breakage? | €Yes | €No |

28. Hiring Practices:

- | | | |
|---|------|-----|
| a. Written employment application required for all prospective employees? | €Yes | €No |
| b. Applications require listing of convictions and a statement that false statements are grounds for dismissal? | €Yes | €No |
| c. Employee's photograph retained in personnel file? | €Yes | €No |
| d. Criminal histories obtained on key employees? | €Yes | €No |
| e. Formalized Training Program? | €Yes | €No |

Please Describe: _____

Additional Coverages

CHECK ALL THAT APPLY

Additional Insureds _____ Individual _____ Blanket
Waiver of Subrogation _____ Individual _____ Blanket
Primary Wording _____ Individual _____ Blanket
Per Project Aggregate _____ Employee Benefits Liability _____
Stop Gap _____ Hired/Non-owned Auto _____

Current General Liability Information

1. Please provide name of carriers, premiums paid, limits, sales, deductibles, and loss runs for the past 5 years.

	YR	YR	YR	YR	YR
Carrier					
Premium					
Payroll					
Ded/SIR					
Losses					

2. Has any company canceled or declined to renew in the past 5 years? €Yes €No

If yes, please explain: _____

3. Has the insured ever had a lapse in coverage? €Yes €No

If yes, please explain: _____

Claim Information

1. Make sure to attach 5 years of currently valued loss runs. (Valued no more than 3 months from date of application.)

2. Do you require staff to report all unusual incidents and are all incident reports reviewed by Management? €Yes €No

3. Do you have any knowledge concerning any incidents that have occurred prior to the date of this application that may give rise to a future claim? €Yes €No

NOTICE TO APPLICANTS: THIS APPLICATION MUST BE COMPLETED IN FULL AS THE QUOTE WILL BE BASED SOLELY ON THE INFORMATION PROVIDED, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME BY SIGNING THIS APPLICATION, THE SIGNOR WARRANTS THAT TO THEIR BEST KNOWLEDGE ALL INFORMATION GIVEN IS TRUE AND ACCURATE.

Name (type or print)

Signature

Date

NOTICE TO PRODUCERS: THE PRODUCER HEREBY WARRANTS THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF THEIR KNOWLEDGE.

Name (type or print)

Signature

Date

License #

Optional Coverages

(please attach an ACORD application)

Property
Business Auto
Crime/Employee Dishonesty

Contractors Equipment
Workers' Compensation
Employment Related Practices

EDP
Umbrella/Excess

Umbrella/Excess Questionnaire

(Please complete only if desired.)

- | | | |
|--|------|-----|
| 1. With the exception of leinholders, are any vehicles not solely owned by and registered to the applicant? | €Yes | €No |
| 2. Do over 50% of the employees use their autos in the business? | €Yes | €No |
| 3. Is there a vehicle maintenance program in operation? | €Yes | €No |
| 4. Are any vehicles leased to others? | €Yes | €No |
| 5. Are any vehicles customized, altered or have special equipment? | €Yes | €No |
| 6. Do operations involve transporting hazardous material? | €Yes | €No |
| 7. Any vehicles used by family members or non employees?
If so, please identify in remarks. | €Yes | €No |
| 8. Does insured review MVRs at time of hire and annually for all driving employees? | Yes | No |
| 9. Does insured have MVR standards in place, and an action plan if those standards are violated? | Yes | No |
| 10. Does insured have a written personal use policy including: who may and may not drive a company owned vehicle, that the company vehicle(s) may or may not be used for outside business, and consequences for violation of the policy? | Yes | No |
| 11. Does insured have a Fleet Safety program in place? | Yes | No |
| 12. Does the applicant have a specific driver recruiting method? | €Yes | €No |
| 13. Are any drivers not covered by Workers' Compensation? | €Yes | €No |
| 14. Any vehicles owned but not scheduled on this application? | €Yes | €No |

Remarks:

WORKERS' COMPENSATION

Information Required with Submission: (Please attach)

1. ACORD Workers' Compensation application
2. Location Coding – see attached pages
3. Financials for accounts over \$100,000
4. Insurance Carrier Premium and Loss statements which are currently valued (5 years required).
5. Drivers schedule: Names, Dates of Birth & Driver's License Number required.
6. Experience Mod. Worksheet
7. Risk Identification Number for the NCCI or Appropriate State Rating Bureau or State Fund:

1. Annual employee turnover rate _____%

2. Is the current coverage now in Assigned Risk, State Fund or Voluntary Market? €Yes €No

3. Has any insurance carrier canceled or refused to renew within the past 3 years? €Yes €No
If yes, please explain _____

4. Do you report all WC claims, regardless of payment having been made on the claim? €Yes €No
If no, please explain: _____

5. Employee Benefits Program: ☐ Group Medical ☐ 401K ☐ Other _____
Describe your Employee Benefits Program: _____

6. Do you have a transitional duty (light duty) program? €Yes €No
If yes, describe: _____

7. Who is responsible for safety? _____

8. Do you have a formal safety committee? €Yes €No
If yes, how frequently does it meet and who attends? _____

9. Do you have a medical or physicians network in place for workers' comp. claims? €Yes €No
If yes, describe in detail: _____

10. Auto/Fleet Exposures (Complete if auto is not submitted with the workers' compensation.)

- a. Number of Drivers: _____
- b. Number of and types of vehicles: _____
- c. How are vehicles used? _____
- d. What time of the day are vehicles used? _____
- e. Who is allowed to drive vehicles? _____
- f. How often are MVR's pulled on all drivers? _____
- g. Describe MVR policy as it relates to vehicle usage: _____

h. Are vehicles taken home? €Yes €No
If yes, what limitations are in place for personal use? _____

i. Is there a maintenance program? €Yes €No

WAIVER SUBROGATION – Provide the names, addresses & class codes/payroll of all contracts requiring a waiver of subrogation.

If the Insured has no exposure to any of the High Profile Locations,
please note "no exposure, and sign/date the form.

WCM Workers' Compensation

High Profile locations / Exposures

Location / Exposure Type	Yes	Comments
Airports		
Public Transportation (Incl. rail, subway stations)		
Monuments & other historically significant loc.		
Convention Centers		
Major Religious Structures		
Stadiums, Arenas or Sporting Complexes		
Museums / Aquariums/ Zoos		
Stock Exchanges or Financial Centers		
Nationally Recognized Hospitals/ Medical Centers		
Amusement Parks (high profile)		
"Marquis" buildings		
Utilities / Energy Generating Stations		
Refineries / Fuel Depots		
Dams		
Hazardous Chemical Manufacturing		
Weapons / Defense Manufacturing		
Military Bases or Locations		
Major Casinos		
Mail Handling or Delivery		
High-Rise Buildings		
Tier 1: Nationally recognized (e.g., Sears Tower)		
Tier 2: Over 35 stories		
Tier 3: Between 20 and 35 stories		
Other Specialty Situations		
Example: Olympic Venues, other Special Events		

Signature: _____

Date: _____

The operations described herein are conducted by RSG Specialty, LLC, a Delaware limited liability company based in Illinois. RSG Specialty, LLC, is a subsidiary of Ryan Specialty, LLC. Thirty-year industry veteran Chris McGovern manages the programs described herein. RSG Specialty works directly with brokers, agents and insurance carriers, and as such does not solicit insurance from the public. Some products may only be available in certain states, and some products may only be available from surplus lines insurers. In California: RSG Specialty Insurance Services, LLC (License #0G97516). ©2022 Ryan Specialty, LLC