



GENERAL LIABILITY & INLAND MARINE CRANE CHECKLIST



A complete submission helps to expedite the underwriting process and allows us to deliver a competitive and comprehensive coverage proposal. Submissions should include the **iii Crane Supplemental Application** (follows), along with:

- 1) Properly completed ACORD applications (General Information, CGL, Umbrella, Auto, etc.).
- 2) Narrative of specialty or type of work done.
- 3) Five (5) years, currently valued, hard copy, company loss runs.
- 4) Expiring terms & pricing.
- 5) Target terms and pricing needed. Also, please include your target date.
- 6) Schedule of equipment that includes the,
 - Age
 - Make
 - Model
 - Boom lengths and lift capacity for each unit
 - Value
- 7) Copy of rental contracts or work agreements, including bare rental contract, if applicable.
- 8) List of major jobs in the last twelve (12) months.
- 9) Names of all Operators, years of experience, and age (use the **iii Operator / Employee Qualifying Information Supplement**)
- 10) Average and maximum hook limits lifted.
- 11) Three (3) years sales history.
- 12) Which policy included the hook coverage for the past five (5) years – the CGL or IM?

Note: All of the above information is required, whether we write mono-line CGL, and/or the CGL and IM.



Crane Supplemental Application



First Named Insured (including all owned or controlled subsidiaries): _____

Street Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Contact person for inspection: _____ Phone: _____

Web site address: _____

SECTION A. GENERAL INFORMATION

- Business type: Individual Partnership Corporation LLC Other: _____
- Number of years in business under the present name? _____ Year this Company was formed? _____
- Do you own any other entities? No Yes (please describe): _____

4. What is your area(s) of operation? _____

5. Desired effective date of coverage: ____/____/____

6. Estimated Breakdown of Gross Receipts and Payroll

PAYROLL

RECEIPTS

a) Millwright work, including machinery installation & repair	\$ _____	\$ _____
b) Steel erection	\$ _____	\$ _____
c) Crane rental with operator	\$ _____	\$ _____
d) Rigging (if done as a complete and separate operation from any of the above)	\$ _____	\$ _____
e) Bare crane rental	\$ _____	\$ _____
f) Heavy hauling	\$ _____	\$ _____
g) Sale of equipment	\$ _____	\$ _____

7. Describe type(s) of work performed and any specific areas of concentration (use separate sheet if necessary):

- _____
- _____
- _____
- _____

8. Describe any wet marine operations/exposures: _____

9. Do you rent equipment other than cranes?

- No Yes (if yes, please describe types of equipment): _____

b. What are annual revenues with operators? \$ _____
 “ “ “ “ without operators? \$ _____

10. Total number of employees: _____

Number of Operators: _____ Number of CCO Certified Operators: _____

Operators and Oilers are: Union Non-union

Describe your screening process for new Operators: _____

SECTION B. SUBCONTRACTOR INFORMATION

11. Do you hire subcontractors? No Yes (if you do, provide subcontracted costs): \$ _____

- a. Do you obtain Certificates Of insurance from all subcontractors? No Yes
- b. Do you require all subs carry minimum limits of \$1,000,000 each occurrence / \$2,000,000 annual aggregate? No Yes
- c. Do you require that all subcontractors include you as an Additional Insured under their policy? No Yes
- d. Are all subcontractors required to contractually hold you harmless? No Yes

PLEASE INCLUDE A COPY OF YOUR SUBCONTRACTORS AGREEMENT WITH THIS APPLICATION

SECTION C. LOSS CONTROL & MAINTENANCE

12. Do you have a,

- a. Formal loss or safety program? No Yes
- b. Scheduled maintenance program? No Yes
- c. Written form for crane inspections? No Yes
- d. Accident report form? No Yes
- e. Are cranes certified? No Yes How often: _____
- f. Are Certificates Of Insurance required from lessees on bare rentals? No Yes
- g. Do you order MVR's on all drivers/operators? No Yes
- h. Do you utilize personnel buckets No Yes
- i. Do you do perform any demolition work? No Yes
- j. What is your minimum age for operators? _____

13. Please provide:

- a. Average "on-hook" value: \$ _____ Maximum "on-hook" value: \$ _____
- b. Average "height of lifts": _____ Maximum "height of lifts": _____
- c. Description of items lifted: _____

14. Please provide/advise regarding the following items:

- a. Schedule of equipment that includes: (1) age; (2) make; (3) model; (4) main boom length & lift capacity; (5) values
- b. Copy of rental contracts with Hold Harmless language in insured's favor
- c. Copy of your Subcontractors Agreement
- d. Schedule of your major jobs for the last twelve (12) months
- e. Schedule of Operators. Please complete the iii **Operator/Employee Qualifying Information Supplement** for each Operator
- f. Five (5) years, currently valued, hard copy, company loss runs.

SECTION D. COVERAGE REQUESTED

Each Occurrence \$ _____
 General Aggregate \$ _____
 Products / Completed Operations Aggregate \$ _____
 Personal & Advertising Injury Aggregate \$ _____
 Fire Legal Liability \$ _____
 Medical Payments \$ _____
 Deductible options: \$2,500 \$5,000 \$10,000 Other: \$ _____

SECTION E. CLAIM HISTORY

Please include with your submission five (5) years, currently valued, hard copy, company loss runs. If there have been no claims / losses, please state "None".

Date of Loss	Description	Amount Paid	Amount Reserved	Status (open / closed)

Please describe any additional incidents that have occurred that may result in a claim or suit being brought against you. If none, so state:

SECTION F. PRIOR POLICY INFORMATION

Policy Period		Insurer	Limits	Premium	Exposure Basis (e.g., receipts, payroll)	Deductible
From	To					
/ / : / /	/ /		\$	\$	\$	\$
/ / : / /	/ /		\$	\$	\$	\$
/ / : / /	/ /		\$	\$	\$	\$
/ / : / /	/ /		\$	\$	\$	\$
/ / : / /	/ /		\$	\$	\$	\$

Has any insurance company in the past five (5) years cancelled or refused to renew your insurance coverage? No Yes

If "Yes", please describe: _____

State Notices: The following notices are required by the Insurance Department of the indicated states.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

THE UNDERSIGNED DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE INSURANCE, NOR DOES REVIEW OF THE APPLICATION BIND THE INSUROR TO ISSUE A POLICY. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

SIGNED BY (please print): _____
 Name Title

Applicant Signature Date

Producer Signature Date

PRODUCER INFORMATION

Agency Name: _____

Producer: _____

Address: _____

email: _____

Phone: _____ Fax: _____



OPERATOR / EMPLOYEE QUALIFYING INFORMATION SUPPLEMENT



Complete a separate form for each Operator.

Name: _____ Birthdate: ____/____/____

Address: _____
(Street) (City) (State) (Zip)

Driver's License #: _____ State: _____

Phone: _____ Wages/Salary: \$ _____

Total years of operating experience: _____

Describe any crane operator/rigging license, training, schools, seminars you have received or attended:

List below all of the type(s) of equipment that you are qualified / trained to operate.

Make	Model	Boom Length / Lift Capacity	Years Experience

Total Years rigging experience: _____

Have you ever been involved in any crane operation losses? No Yes If so, please provide,

- Date: ____/____/____ Bodily Injury Amt. \$ _____ Property Damage Amt. \$ _____
- Date: ____/____/____ Bodily Injury Amt. \$ _____ Property Damage Amt. \$ _____
- Date: ____/____/____ Bodily Injury Amt. \$ _____ Property Damage Amt. \$ _____

List the Crane Company(ies) for which you are currently / were formerly employed:

- Name: _____ From: ____/____/____ To: ____/____/____
- Name: _____ From: ____/____/____ To: ____/____/____
- Name: _____ From: ____/____/____ To: ____/____/____

Signature of Operator: _____ Date: ____/____/____

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PERSONNEL BASKET SUPPLEMENTAL APPLICATION



1. Do you ever use any owned or non-owned personnel baskets or any other devices to raise or lower people?
 No Yes If yes, describe in detail the work / operations performed. _____

2. What percentage of your total sales is related to personnel basket work? _____ %
3. What is your relationship with the individuals being lifted in these devices?
 - a. Are they your employees? No Yes
 - b. Employees of others? No Yes Please describe: _____

4. Do you carry Workers Compensation coverage? No Yes If Yes, please tell us,

Insurer Name	Policy Number	Policy Effective Date	Policy Expiration Date
5. If lifting individuals other than your employees please confirm that a Workers Compensation policy is in place for those individuals by providing a Certificate Of Insurance that shows (a) Insurer name (b) Policy number (c) Policy effective and expiration dates
6. Provide a description of the training/experience regarding safety issues for each individual who either operates or occupies the personnel bucket: _____

7. Is the use of a harness mandatory with all personnel lifting operations? No Yes If Yes, provide details: _____

8. Confirm that there is a maximum of one (1) person per bucket permitted, with no more than two(2) buckets being lifted at one time. _____
9. Does the Named Insured's rental contract include a Hold Harmless? No Yes

Please provide a copy of the rental agreement.

Named Insured	Title
Signature	Date: ____ / ____ / ____

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RENTAL CONTRACT GUIDELINES



As a requirement for the Commercial General Liability coverage provided, the Insured must have, and use, a written contract for all work. If the Insured does not currently have this, the insurer will only provide sixty (60) days of coverage after the inception date of the policy to allow for the implementation of this document. Please have a copy of this document sent to our office immediately in order to avoid jeopardizing coverage.

As laws and rules vary by state, we strongly encourage the Insured to seek and obtain advice from legal counsel in this process so that they may obtain the maximum legal protection afforded them in their jurisdiction.

While we cannot recommend wording for this, the contract language should include, at a minimum, the following:

- A brief description of the work to be done. The contract **MUST** be signed by **BOTH** the customer and the Insured.
- Limit the Insured's responsibility to THEIR own actions.
- A Hold Harmless and Indemnification clause for loss or damage for work that is beyond the scope of the job the insured was hired to do or for work or duties being performed by the client. This clause must include language that the client is responsible if the Insured is working under the direction and/or control of the client if the client provides rigging equipment or materials; provides employees or workers who do the rigging of the load to be lifted, or provides helpers or signal persons.
- Wording that absolves the Insured from any and all damages to improved surfaces (e.g., concrete, asphalt) resulting from the operation of the equipment.

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BARE CRANE RENTAL SUPPLEMENT



1. What percentage of your total sales are directly related to bare rentals? _____%
2. Confirm that your lease agreement has a “*Hold Harmless*” clause and “*Operator is qualified to operate this crane*” language. Please provide a copy of the signed lease agreement.
3. Verify that the insured has a Certificate Of Insurance on file naming them as Additional Insured on the Lessee’s policy, prior to the equipment being rented. Provide a copy of the Certificate Of Insurance.

Named Insured

Title

Signature

Date: ____/____/____

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EMPLOYEE BENEFIT LIABILITY INSURANCE SUPPLEMENTAL APPLICATION



Employee Benefit Programs which are automatically covered are: Group Life Insurance, Profit Sharing Plans, Pension Plans, Employee Stock Subscription Plans, Workers Compensation Unemployment Insurance, Social Security and Disability Benefits Insurance.

1. Name of applicant: _____
2. Address: _____

3. Policy: _____
4. Number of employees: _____
5. Does Insured administer or self-insure the Medical Plan? No Yes
6. Prior Carrier: _____
 - a. Claims Made Form? No Yes If Yes, Retroactive date: ____/____/____
 - b. Occurrence Form? No Yes
7. Any claims in the last five (5) years? No Yes
8. If Retroactive date is more than one (1) year, provide all prior carriers: _____

