

Covid-19 Supplemental

General

1. Legal Entity Name:

Employee

2. Total number of employees

Full-Time Employee(s)

Part-Time Employee(s)

2.1. Any location with more than 30 employees? () Yes () No

2.1a. If yes, what is the maximum number of employees at the location Employees _____

2.1b. If shift work, please provide the employee breakdown by shift

 Shift 1
 Shift 2
 Shift 3

3. Please describe your mandatory Covid-19 vaccination policy or your policy requiring face coverings in the workplace and mandatory weekly Covid-19 testing policy.

4. Are the payroll estimates provided consistent with your current operations?



4.2. Date of most recent positive test: _____

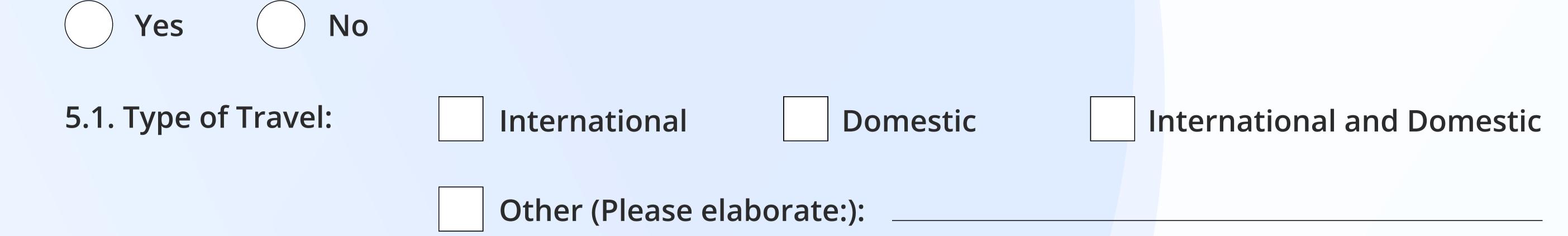
4.3. Number of positive tests reported as WC claims:



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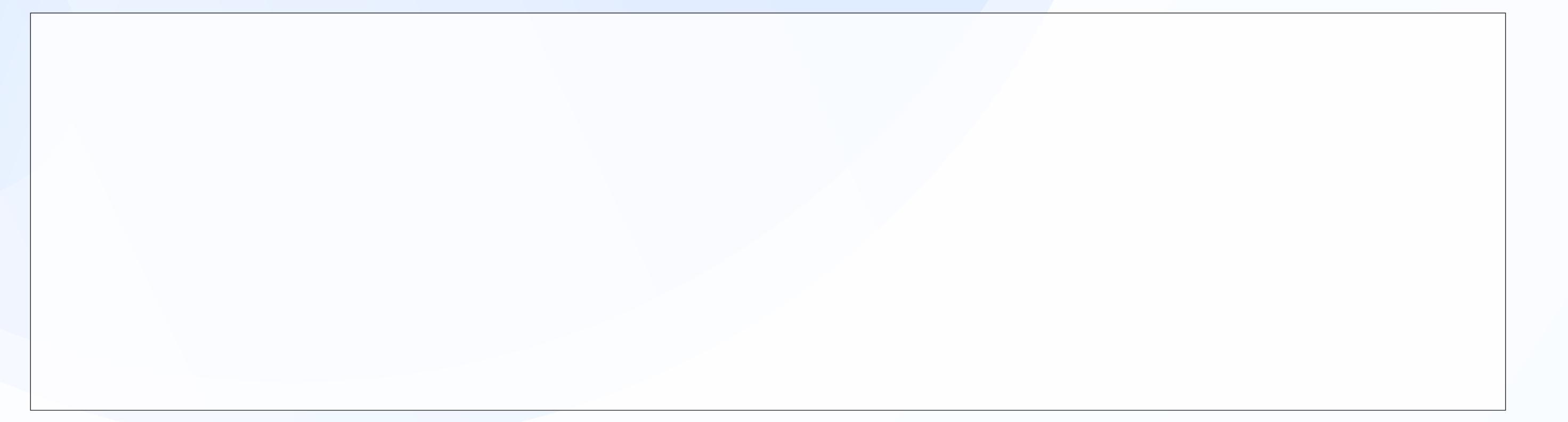
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5. Do you currently have any travel outside of your normal radius of operations?



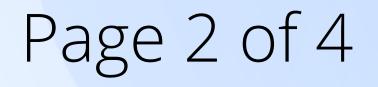
Exposure Management

6. What Personal Protective Equipment (PPE) is provided? How are employees trained in their use? Please elaborate:



7. What screening practices are in place for both employees and visitors? Please elaborate:

8. How often are employee screenings conducted?



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9. Is a written record of screening maintained?

10. What procedures are in place for managing an employee suspected of or diagnosed with COVID-19? Please elaborate:

11. What procedures are in place to practice social distancing with other employees, customers, and guests. Please elaborate:

12. Do facilities have instructional signage, use of barriers, or other controls related to exposure management? Please elaborate:

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13. What new housekeeping, deep cleaning, and disinfecting procedures have been put in place to help prevent the transmission of COVID-19 throughout the workplace? Please elaborate:

Applicant Name:

Applicant Signature:

Applicant Title:

Must be signed by an authorized Representative of the Insured. If you are unable to provi-de a digital signature, please print out the finalized form and provide a wet signature.

Date:

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