WORTH & COMPANY, INC

SUPERIOR CUSTOMER SERVICE. INNOVATIVE SOLUTIONS.

For Internal Use Only: Approvals

Safety ____________

BUL/PM ____________

Purchasing ____________

Please complete this form and forward it by email to:

Contact ____

All disclosures of information by your company will be treated confidentially.

Date: ____

Legal Name of Company: ____

D&B Number (if applicable): ____

Registered Address: ____

Primary Contact: ____

Primary Phone Number: ____

Estimator Name: ______________________________ Phone # & Email Address: ____________________________

Briefly describe the primary area of business specialization, trade or products.

____

____

Trade References

1 - Company Name ______________________________________

Contact Name __________________________ Phone # ____________________

Email Address ____

2 - Company Name ______________________________________

Contact Name __________________________ Phone # ____________________

Email Address ____

3 - Company Name ______________________________________

Contact Name __________________________ Phone # ____________________

Email Address ____

State Licenses

In which states are you licensed:

____

____

____

Certifications

_____________ MBE

_____________ DBE

_____________ WBE

_____________ Other

Claims and Suits

Has your organization ever failed to complete any work awarded to it? ____________ Yes __________ No

If yes, please attach explanation.

Are there any judgments, claims, arbitration proceedings or suits pending or outstanding against your organization or its officers? ____________ Yes __________ No

If yes, please attach explanation.

Has your organization filed any lawsuits or requested arbitration with regard to construction contracts within the last five years? ____________ Yes __________ No

If yes, please attach explanation.

Insurance Company _______________________________

Insurance Agent _____________________________________

Insurance Agent Phone ___________________

Insurance Interstate Experience Modification for the last three (3) years:

20__ _____________ 20__ _____________ 20__ _____________

Total Number of Employees: ____________________

If total number of employees is 9 or under, the chart below can be left blank.

Last 3 Years	NAICS Code	TRIR	DART	Hrs. Worked	# Employees
20					
20					
20					

Provide in attachment a copy of your safety program.

Provide in attachment three (3) years of OSHA 300 reports.

Provide the name, title and contact information for your organization's safety representative.

Signature ________________________________

Printed Name ________________________________

Title ________________________________

PLEASE CONFIRM THE FOLLOWING LIMITS/COVERAGES WITH YOUR INSURANCE BROKER
****SEE NEXT PAGE****

Financial information will be requested at a later date via secure link.

PLEASE CONFIRM THE FOLLOWING LIMITS/COVERAGES WITH YOUR INSURANCE BROKER

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): Today's Date

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
ABC Company
123 Anywhere Street
Anywhere, USA 12345-1234

CONTACT NAME:
PHONE (A/C, No, Ext): | **FAX (A/C, No):**
E-MAIL ADDRESS:
PRODUCER CUSTOMER ID #:

INSURED
DEF Contractor
123 Your Street
Your Town, USA 1111-2222

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ABC	
INSURER B : DEF	
INSURER C : GHI	
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	**GENERAL LIABILITY** X COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY X PRO-JECT ☐ LOC			TBD	TBD	TBD	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
B	**AUTOMOBILE LIABILITY** X ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			TBD	TBD	TBD	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
								$
C	X **UMBRELLA LIAB** X OCCUR ☐ **EXCESS LIAB** ☐ CLAIMS-MADE ☐ DEDUCTIBLE ☐ RETENTION $			TBD	TBD	TBD	EACH OCCURRENCE	$ 2,000,000
							AGGREGATE	$ 2,000,000
								$
								$
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		TBD	TBD	TBD	X WC STATU-TORY LIMITS ☐ OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

All parties, where required by contract, are Additional Insureds on the GL, Auto and Umbrella policies on a primary and non-contributory basis. Waiver of Subrogation is provided on all lines of coverage. Workers' Compensation coverage applies to the state where the work is performed. All policies provide 30 days notice of cancellation.

CERTIFICATE HOLDER

Worth & Company, Inc.
6263 Kellers Church Road
Pipersville, PA 18947

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Authorized Representative's Signature Here

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