



8502 Via De Ventura Ste 220 Scottsdale AZ 85258  
 Phone - 800-233-1880 Fax Quote-402-342-0096  
 Email Quotes – [Obu-quotes@mcm-ins.com](mailto:Obu-quotes@mcm-ins.com)

**TEMPORARY EMPLOYMENT AGENCIES SUPPLEMENT**  
 (Include Acord Application)

Applicant's Name: \_\_\_\_\_ Location Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

- 1) Is applicant properly licensed where required by law?  Yes  No License Number \_\_\_\_\_
- 2) Number of active owners/officers/partners: \_\_\_\_\_ Number of Employees \_\_\_\_\_
- 3) Does applicant carry Workers' Compensation coverage on temporary employees?  Yes  No
- 4) Does applicant subcontract work to others?  Yes  No  
 If yes, are certificates of insurance required?  Yes  No
- 5) Do subcontractors name the applicant as additional insured?  Yes  No
- 6) Are reference/background checks required on all temporary employees?  Yes  No
- 7) Does the applicant provide leased employees to others?  Yes  No
- 8) Any assignment of temporary workers longer than six months?  Yes  No
- 9) Estimated annual: Payroll (excl. owner) \_\_\_\_\_ Receipts \_\_\_\_\_ Subs Costs \_\_\_\_\_  
 Please provide payroll breakdown between: Clerical \_\_\_\_\_ and Non-clerical \_\_\_\_\_
- 10) Does applicant require leasing client to cover employees under their GL coverage?  Yes  No  
 (Leased employee exclusions are not acceptable)

**Please provide breakdown of all Non-clerical operations.**

Light Industrial (List Classes)	Payroll	%	Heavy Industrial	Payroll	%	Professional	Payroll	%
			Retail	Payroll	%	Contracting	Payroll	%

**Attach a copy of the applicant's contract(s) last Workers Compensation audit.**

The Applicant, Agent and/or Broker represents that the above statements and facts are true and that no material facts have been suppressed or misstated.

Completion of this form does not bind coverage or commit the Company to policy issuance.

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits and application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

Applicant: \_\_\_\_\_ Producer: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_ Signature: \_\_\_\_\_ Date \_\_\_\_\_