

**OLD REPUBLIC GENERAL INSURANCE CORPORATION  
NEW YORK APPLICATION FOR DRUG FREE WORKPLACE PREMIUM CREDIT PROGRAM**

\_\_\_\_\_  
Name of Employer

\_\_\_\_\_  
Address of Employer

\_\_\_\_\_  
Date Program Implemented

Please attach a copy of employer's written substance abuse policy

**Education**

\_\_\_ Supervisory training                      How long \_\_\_\_\_

\_\_\_ Employee education                      How long \_\_\_\_\_

\_\_\_ Employee Assistance Program or Community Health Services Directory

\_\_\_\_\_  
Name and address of Employee Assistance Program

\_\_\_\_\_  
Phone Number

**Notice of Employer's Drug Testing Policy:**

\_\_\_ Copy to all employees prior to testing

\_\_\_ Posted on employer's premises

\_\_\_ Show notice of drug testing on vacancy announcements

\_\_\_ Copies available in personnel office or other suitable location

\_\_\_ Copy to job applicant

**Testing:**

Drug testing has been conducted in the following area: (check all that apply)

\_\_\_ Job applications                                      \_\_\_ Random testing

\_\_\_ Reasonable suspicion                                      \_\_\_ Follow-up to EAP/Rehabilitation

\_\_\_ Post Accident

\_\_\_\_\_  
Name and address of Medical Review Officer

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Name and address of DHHS Certified Lab

\_\_\_\_\_  
Phone #

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

\_\_\_\_\_  
Applicant Officer/Owner Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Applicant Officer/Owner Signature

\_\_\_\_\_  
Date

**THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL  
DEPICTION OF THEIR CURRENT PROGRAM**

\_\_\_\_\_  
Notary Public's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Expiration of Commission

This application is to be completed, signed, notarized and returned to your agent or broker, who will forward it to the carrier as proof of the existence of a certified program.