

## Subcontractor Prequalification Form

Complete all sections before awarding work. Retain on file for the duration of the relationship.

Date submitted

GC company / project name

### 01 COMPANY INFORMATION

Legal entity name (must match license and insurance exactly)

DBA / trade name (if different from legal name)

Physical business address (no PO Boxes)

Primary contact name

Title

Phone

Email

Years in business

Federal EIN (for W-9)

**Business entity type:**

LLC

S-Corp

C-Corp

Sole Proprietor

Partnership

### 02 LICENSE INFORMATION

License number

Issuing state

License classification / type

License expiration date

Responsible Managing Employee (RME) or Officer (RMO) name

License verification URL and date confirmed

### 03 INSURANCE REQUIREMENTS

Fill in the minimum limits required for your project type before distributing this form.

#### General Liability (occurrence form required)

Per occurrence minimum \$ \_\_\_\_\_

Aggregate minimum \$ \_\_\_\_\_

Policy number \_\_\_\_\_

Policy expiration date \_\_\_\_\_

#### Workers' Compensation

Coverage:

Statutory limits

Sole proprietor exemption (attach documentation)

Employer's Liability each accident \$ \_\_\_\_\_

Policy expiration date \_\_\_\_\_

#### Commercial Auto Liability (if vehicles on site)

Combined single limit \$ \_\_\_\_\_

Policy expiration date \_\_\_\_\_

#### Umbrella / Excess Liability

Limit \$ \_\_\_\_\_

Policy expiration date \_\_\_\_\_

Follow-form confirmed (including additional insured and primary/noncontributory)

#### Required Endorsements

All four endorsements must appear on the policy. Note the endorsement form number where indicated.

Additional insured — ongoing operations (CG 2010 or equivalent) Form #: \_\_\_\_\_

Additional insured — completed operations (CG 2037 or equivalent) Form #: \_\_\_\_\_

Primary and noncontributory

Waiver of subrogation — General Liability, Workers' Compensation, and Umbrella

Insurance carrier \_\_\_\_\_

Agent name \_\_\_\_\_

Agent phone \_\_\_\_\_

## 04 FINANCIAL & SAFETY

Experience Modification Rate (EMR)

EMR year

Attach EMR letter from insurance carrier. Flag: above 1.0 = yellow, above 1.25 = red.

### OSHA citations in the last 3 years?

No

Yes — describe below

If yes, describe

### References (minimum 2 — from other general contractors):

#### Reference 1

GC company name

Contact name

Project type

Phone

#### Reference 2

GC company name

Contact name

Project type

Phone

Bonding capacity (if required for this project) \$

## 05 W-9

Completed W-9 attached

Legal name on W-9 (must match Section 1 legal entity name exactly)

EIN or SSN is captured on the W-9 itself. Verify it matches the EIN in Section 1.

## 06 CERTIFICATION & SIGNATURE

I certify that the information provided in this form is accurate and complete to the best of my knowledge. I agree to notify the GC of any material change to my license status, insurance coverage, or business structure within 10 business days of such change. I agree to maintain the insurance coverage levels specified in this form for the duration of any work performed and to provide updated certificates of insurance upon request.

Authorized signature

Date

Printed name

Title / position

**FOR GC USE ONLY — DO NOT RETURN TO SUBCONTRACTOR**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>License verified</b>	Verified by:	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>COI received and compliant</b>	Received date:	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Endorsements confirmed</b>	Form numbers noted:	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>W-9 on file</b>	Date received:	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>EMR acceptable (EMR: _____)</b>	Threshold met:	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>References checked</b>	Notes:	_____

Approved by \_\_\_\_\_ Date approved \_\_\_\_\_