

Supplemental Questionnaire

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicant Information:

Proposed Effective Date:	Legal Name:	Application ID:
Application completed by: Broker: <input type="checkbox"/> Employer: <input type="checkbox"/>		
Please provide (first, last) name: _____		Date: _____

General Classification Evaluation:

- 1) Maximum height exposure: ___ Ft. N/A
If applicable - Method of reaching height exposures: (Check all that apply)
 Ladder Scaffolding Scissor Lifts Other: _____
- 2) Maximum weight lifted: ___ lbs. N/A
If applicable: Manual Lifting Employee(s) lifts with assistance: Please explain: _____
 Please list the typical types of items lifted: _____
- 3) Vehicle exposure: Yes No
If Yes -
 Percentage of total operations: _____% Total # of vehicles _____
 Number of employee drivers: _____ Do employees take the vehicle home overnight? Yes No

 Driving radius in miles: _____ mi. GPS tracking system installed? Yes No
 MVRs checked? Yes No Company-Owned? Yes No
 PUC Filing: N/A Yes: _____ MCP Filing: N/A Yes: _____
- 4) Any out of state, international, or overnight travel: Yes No
If Yes - Please provide:
 Number of employees traveling: _____ Location(s): _____
 Method of transportation: _____ Frequency of travel: _____
- 5) CPR training provided: Yes No If Yes - Number of employees certified: _____

Claims Handling:

- 1) Is there a set procedure for reporting claims? Yes No
- 2) Is there a formal written accident investigation report? Yes No
- 3) Do you currently participate in an MPN program to control claim costs? Yes No

Personnel Practices:

- 1) New-hire orientation program: Yes No Is the orientation documented? Yes No
- 2) Owner is active in daily operations: Yes No
- 3) Employee Handbook: Yes No
- 4) Post-accident drug testing: Yes No
- 5) Job specific training: Yes No
- 6) Performance Appraisals: Yes No
- 7) Wellness program in place: Yes No
- 8) Are any of the following benefits provided?
 Medical: No Yes: Employer contribution: ___% Percentage of employees enrolled: ___%
 Retirement: No Yes: Employer contribution: ___% Percentage of employees enrolled: ___%
- 9) Any other information in regard to employee benefits? If so, please provide those details:

Employer-Employee Relationship:

- 1) Employee turnover rate (annually): ____% Average tenure of employees (in # of years): ____
- 2) Number of employees hired:
 Full Time (annual): ____ Payroll Estimate: \$ ____
 Part Time/Seasonal: ____ Payroll Estimate: \$ ____
- Number of seasonal employees: ____
 Seasonal employee period (From Month: _____ to Month: _____)

Safety Program/Practices which are implemented and enforced:

- 1) Fall Protection Plan: Yes No N/A
- 2) Heat and illness prevention program: Yes No N/A
- 3) Do you maintain a Workplace Violence Prevention Plan? Yes No N/A
- 4) Respiratory program: Yes No N/A
- 5) Driver safety training plan: Yes No N/A
- 6) Forklift training & safety plan: Yes No N/A
- If Yes – Annual certification required:** Yes No N/A
- 7) MSDS available for all chemicals/products used: Yes No N/A
- 8) Written lockout/tag out/block out procedures: Yes No N/A
- 9) Hazardous chemicals safety plan: Yes No N/A
- 10) Confined spaces plan: Yes No N/A
- 11) Active safety incentive program for all employees: Yes No N/A
- 12) Are supervisors held accountable for a safe work environment? Yes No N/A
- 13) Is there a dedicated full time safety manager? Yes No N/A

If Yes – Please provide:

Name: _____ Title: _____

- 14) Safety meetings are conducted: Daily Weekly Monthly Quarterly Does not conduct safety meetings
 Are safety meetings documented? Yes No
- 15) Personal protective equipment provided to all employees: No Yes, please list types: _____
- 16) Employee to Supervisor ratio: ____ / ____
- 17) What loss prevention recommendations has the insured implemented? Loss control service has not been performed.
 Year implemented: _____

Machinery and Equipment:

- 1) Please list the types of machinery/equipment used: _____ N/A
- 2) Are all equipment operators certified? Yes No
- 3) Are all machineries/equipment properly guarded? Yes No
- 4) Age of equipment in years: 0-5 5-10 10-20 20+
- 5) Condition of the equipment: Excellent Good Average Poor
- 6) Who is responsible for maintaining machinery? Insured Contractor Other: _____

Sub-Contracted Work:

Percentage of work sub-contracted out: ____% Are certificates collected annually for sub-contractors? Yes No

Please explain the type of work sub-contracted out:

Is there any other information about your company, operations, or practices you have implemented which could have an impact on mitigating injuries?