Automotive Services - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date:	Legal Name:	Application ID:

Application completed by: Broker: ☐ Employer: ☐

Please provide (*first, last)* name: ______________________________ Date: ______________________________

Is this risk a gas station? Yes ☐ No ☐ **If yes -** Hours of operation: ☐ 24/7 or, ______am ______pm Security cameras installed? Yes ☐ No ☐ Bullet proof cashier booth? Yes ☐ No ☐ Drop safe registers? Yes ☐ No ☐	Is the insured involved with auto repairs? Yes ☐ No ☐ **If yes –** How many employees are ASE certified? ______ Please describe the type of repairs performed and on what types of vehicles:
Is there a mini market onsite: Yes ☐ No ☐ Car wash service? No ☐ Yes - Self-service: ☐ Full service: ☐	Does the insured offer towing or roadside services: Yes ☐ No ☐ **If yes:** Contract services? Yes ☐ No ☐ 24 hour service? Yes ☐ No ☐ Any road repair services? Yes ☐ No ☐

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: No ☐ If yes, please answer the following:
   Any test driving of vehicles? Yes ☐ No ☐ Percentage of total operations: ____ %

   Any transportation of customers? No ☐ Yes, using: ☐ Company-Owned Vehicle ☐ Personal or Customers Vehicle ☐ Both

   If using company-owned vehicles:
   Total # of vehicles: _____ Number of employee drivers: _____ Driving radius in miles: ____ mi.

   GPS tracking system installed? Yes ☐ No ☐ MVR's Checked? 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: ____
   Method of transportation: ________________ Location(s): ______________________________
   Frequency of travel: ____________________ ______________________________

5) CPR training provided: No ☐ Yes ☐ **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 ☐

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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) Respiratory program: Yes ☐ No ☐ N/A ☐
4) Driver safety training plan: Yes ☐ No ☐ N/A ☐
5) Forklift training & safety plan: Yes ☐ No ☐ N/A ☐
   If Yes – Annual certification required: Yes ☐ No ☐ N/A ☐
6) MSDS available for all chemicals/products used: Yes ☐ No ☐ N/A ☐
7) Written lockout/tag out/block out procedures: Yes ☐ No ☐ N/A ☐
8) Hazardous chemicals safety plan: Yes ☐ No ☐ N/A ☐
9) Confined spaces plan: Yes ☐ No ☐ N/A ☐
10) Active safety incentive program for all employees: Yes ☐ No ☐ N/A ☐
11) Are supervisors held accountable for a safe work environment? Yes ☐ No ☐ N/A ☐
12) Is there a dedicated full time safety manager? Yes ☐ No ☐ N/A ☐
    If Yes – Please provide:
    Name: ________________________________ Title: ________________________________
13) Safety meetings are conducted: ☐Daily ☐Weekly ☐Monthly ☐Quarterly ☐Does not conduct safety meetings
    Are safety meetings documented? Yes ☐ No ☐
14) Personal protective equipment provided to all employees: No ☐ Yes, please list types: -
    ____
15) Employee to Supervisor ratio: _____ / _____
16) What loss prevention recommendations has the insured implemented? ☐ Loss control service has not been performed.

    Year implemented: __________
    [Text here]

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/equipments 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: ______________________

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

[Text here]

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