

# Janitorial - Industry 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: _____		
Which of the following best describes the insured's operations? <input type="checkbox"/> Commercial office cleaning <input type="checkbox"/> Residential Cleaning <input type="checkbox"/> Other: _____		
Are employees supervised? No <input type="checkbox"/> Yes: Direct <input type="checkbox"/> Roving <input type="checkbox"/> Do employees work in pairs or more? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Percentage of work sub-contracted out: _____% Are certificates collected annually for sub-contractors? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please explain the type of work sub-contracted out: _____		
Does the insured perform any of the following? (Check all that apply)		
<input type="checkbox"/> General cleaning	<input type="checkbox"/> Debris Clearing	<input type="checkbox"/> Crime scene clean-up
<input type="checkbox"/> Industrial cleaning	<input type="checkbox"/> Snow removal	<input type="checkbox"/> Graffiti removal
<input type="checkbox"/> Ceiling Tile cleaning	<input type="checkbox"/> Maid/housekeeping services	<input type="checkbox"/> Pest Control
<input type="checkbox"/> Parking lot cleaning	<input type="checkbox"/> Pressure or steam	<input type="checkbox"/> Landscaping
<input type="checkbox"/> Carpet cleaning	<input type="checkbox"/> Fire/Flood/Restoration	<input type="checkbox"/> Chimney cleaning
<input type="checkbox"/> Waxing/polishing of floors and walls	<input type="checkbox"/> Water/fire damage restoration	<input type="checkbox"/> Fire Extinguisher refilling, service repair
<input type="checkbox"/> Exterior window cleaning	<input type="checkbox"/> Aluminum nitrate handling	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Gutter cleaning	<input type="checkbox"/> Solar panel cleaning	

## 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:  \_\_\_\_\_  
 If scaffolding is used, does the insured build their own? No  Yes - \_\_\_\_\_% of annual operations compared to total operations.
- 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  Yes   
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   
 MVR's 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 employee's traveling: \_\_\_\_\_  
 Method of transportation: \_\_\_\_\_ Location(s): \_\_\_\_\_  
 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 a 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: \$ \_\_\_\_\_  
  
 No. 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 provide 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: \_\_\_\_\_  
 Please explain:

**Machinery and Equipment:**

- 1) Please list the types of machinery/equipment used: \_\_\_\_\_ N/A
- 2) Are all equipment operators certified? Yes  No
- 3) Is all machinery/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: \_\_\_\_\_

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

[Text here]