



Agriculture / Farming - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date:	Legal Name:	Application ID:
--------------------------	-------------	-----------------

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.

Application completed by: Broker: <input type="checkbox"/> Employer: <input type="checkbox"/>	
Please provide (first, last) name: _____ Date: _____	
Business operations include: <input type="checkbox"/> Custom Harvester <input type="checkbox"/> Grower <input type="checkbox"/> Packer <input type="checkbox"/> Labor Contractor <input type="checkbox"/> Other: _____ Please select all that apply: <input type="checkbox"/> Alfalfa/Hay/Cereal Grains <input type="checkbox"/> Citrus <input type="checkbox"/> Cotton <input type="checkbox"/> Dairy Farm <input type="checkbox"/> Deciduous fruit <input type="checkbox"/> Livestock <input type="checkbox"/> Melons/pumpkins <input type="checkbox"/> Nut crops <input type="checkbox"/> Potatoes/Sugar Beets <input type="checkbox"/> Strawberries/Bush berries <input type="checkbox"/> Truck Farm <input type="checkbox"/> Vineyard <input type="checkbox"/> Other: _____	Farm Operations: Manually Harvested _____ % Mechanical Harvesting _____ % Harvested by Others _____ % Total: 100 % Are pruning operations performed by employees? Yes <input type="checkbox"/> No <input type="checkbox"/> Any crop-dusting operations? Yes <input type="checkbox"/> No <input type="checkbox"/> Any crops/orchards located on hillsides or slopes? Yes <input type="checkbox"/> No <input type="checkbox"/> Pesticides/Fertilizers are applied by: Employees: <input type="checkbox"/> Outside Vendor: <input type="checkbox"/>
If the business operates a Dairy Farm, please answer the following, or check: <input type="checkbox"/> My business does not operate a dairy farm. Size of dairy herd: _____ Does risk grow own feed? Yes <input type="checkbox"/> No <input type="checkbox"/> Milking barn is: Flat <input type="checkbox"/> Elevated <input type="checkbox"/> Average # of milking's per day: _____ Are proper safety procedures in place for near stem pipes, lagoons or sump pumps? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Vehicle exposure: N/A <input type="checkbox"/> If applicable, please answer the following; Group transportation? No <input type="checkbox"/> Yes: Avg. # of employees per vehicle: _____ Please explain reason for group transportation: _____ Does the risk deliver any products? Yes <input type="checkbox"/> No <input type="checkbox"/> Total # of Vehicles: _____ Number of employee drivers: _____ Do employees take the vehicle home overnight? Yes <input type="checkbox"/> No <input type="checkbox"/> Radius in miles: _____ mi. GPS tracking system installed? Yes <input type="checkbox"/> No <input type="checkbox"/> MVR's Checked: Yes <input type="checkbox"/> No <input type="checkbox"/> Company Owned Vehicles: Yes <input type="checkbox"/> No <input type="checkbox"/> PUC Filing: N/A <input type="checkbox"/> Yes: _____ MCP Filing: N/A <input type="checkbox"/> Yes: _____
Is housing provided? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, # of employees who are provided with housing: _____ Are ATVs used? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many ATVs are used? _____	Are any of the employees relatives of the business owner: Yes <input type="checkbox"/> No <input type="checkbox"/> Number of employees who are relatives: _____ If yes: Are the relatives included in the payroll estimates? Yes <input type="checkbox"/> No <input type="checkbox"/>

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? Yes No
- 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) Any Out of State, International, or Overnight Travel: No If Yes, please provide the following:
 Number of employees traveling: _____
 Method of transportation: _____ Location(s): _____
 Frequency of travel: _____
- 4) 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: \$ _____
 - 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) Extreme temperature program meets Cal OSHA Requirements: Yes No N/A
- 5) Respiratory program: Yes No N/A
- 6) Driver safety training plan: Yes No N/A
- 7) Forklift training & safety plan: Yes No N/A
 - If Yes – Annual Certification required:** Yes No N/A
- 8) MSDS available for all chemicals/products used: Yes No N/A
- 9) Written Lockout/Tag out/Block out Procedures: Yes No N/A
- 10) Hazardous chemicals safety plan: Yes No N/A
- 11) Confined spaces plan: Yes No N/A
- 12) Active safety incentive program for all employees: Yes No N/A
- 13) Are supervisors held accountable for a safe work environment? Yes No N/A
- 14) Is there a dedicated full time safety manager? Yes No N/A
 - If Yes – Please provide:**
Name: _____ Title: _____
- 15) Safety meetings are conducted: Daily Weekly Monthly Quarterly Does not conduct safety meetings
Are safety meetings documented? Yes No
- 16) Personal Protective equipment provide to all employees: No Yes, please list types: _____
- 17) Employee to Supervisor ratio: _____ / _____
- 18) 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/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]