

Automotive Services - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date:	Legal Name:	Application ID:
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Application completed by: Broker: Employer:

Please provide (first, last) name: _____ Date: _____

<p>Is this risk a gas station? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes - Hours of operation: <input type="checkbox"/> 24/7 or, ____am ____pm</p> <p>Security cameras installed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Bullet proof cashier booth? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Drop safe registers? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Is the insured involved with auto repairs? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes – How many employees are ASE certified? _____</p> <p>Please describe the type of repairs performed and on what types of vehicles:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
<p>Is there a mini market onsite: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Car wash service? No <input type="checkbox"/> Yes - Self-service: <input type="checkbox"/> Full service: <input type="checkbox"/></p>	<p>Does the insured offer towing or roadside services: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes: Contract services? Yes <input type="checkbox"/> No <input type="checkbox"/> 24 hour service? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Any road repair services? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

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

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:**
- 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]