



Construction - 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>Indicate percentage of work conducted in each of the following:</p> <p>Commercial: ___% Residential: ___% = 100%</p> <p>Interior: ___% Exterior: ___% = 100%</p> <p>New construction: ___% Remodeling/Service/Repair: ___% = 100%</p> <p>Percentage of jobs with roof top exposure: ___% <input type="checkbox"/> N/A</p> <p>24/7 service? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Any use of cranes, booms, or similar heavy construction equipment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Any work with asbestos, hazardous product abatement, chemical/petroleum products, USL&H, underground tank or pipe replacement? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details: _____</p> <p>Any interchange of labor? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain: _____</p>	<p>Percentage of work sub-contracted out: _____%</p> <p>Please explain the type of work sub-contracted out: [text here]</p> <p>Are certificates collected annually for sub-contractors? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>CSLB Qualifiers Name: _____ Classification assigned: _____ Payroll: \$ _____</p> <p>Please provide a brief description of the qualifier's duties: _____</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: _____
 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 employees 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 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) 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) Extreme temperature program meets Cal OSHA Requirements: 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: _____
[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) 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]