

Janitorial - 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: _____

Which of the following best describes the insured's operations? Commercial office cleaning Residential Cleaning Other: _____

Are employees supervised? No Yes: Direct Roving Do employees work in pairs or more? Yes No

Percentage of work sub-contracted out: _____% Are certificates collected annually for sub-contractors? Yes No

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:

- 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.
- 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: _____
- 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: _____
- 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: _____
- CPR Training provided: Yes No **if Yes** - Number of Employees certified: _____

Claims Handling:

- Is there a set procedure for reporting claims? Yes No
- Is there a formal written accident investigation report? Yes No
- 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:**
- 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) 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]