

# 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: \_\_\_\_\_

## 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: Yes  No   
**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: \_\_\_\_ Location(s): \_\_\_\_\_  
 Method of transportation: \_\_\_\_\_ 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 regards 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:**      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) 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/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: \_\_\_\_\_

**Sub-Contracted Work:**

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

Please explain the type of work sub-contracted out: \_\_\_\_\_

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

[Text here]