

Supplemental Questionnaire for Staffing Agencies and Professional Employer Organizations

Applicant Information
Application ID/Policy Number:
Legal Name of Staffing Agency or Professional Employer Organization:
Trade Names of Staffing Agency or Professional Employer Organization:

GENERAL INFORMATION – Please provide detailed responses.

1. List all legal names, trade names, and/or DBA's you operate under.

2. List all businesses that any owner/officer have any affiliation, interest, or ownership with, including other staffing agencies or labor contractors.

3. Which insurers are these businesses insured with?

4. Provide a detailed description of business operations for each entity listed above.

5. Are any of the entities listed above part of a franchise? Yes No If Yes, please explain.

6. Describe any operations and/or the job of any employees, who work outside of California, including foreign travel?

7. Do any of your workers come from out-of-state? Yes No If Yes, please explain.

8. Do you pay any type of allowances, per diem or lodging? Yes No If Yes, please describe.

9. Provide a list of any current contractual relationship (or an intent to contract) with another Staffing Agency, Labor Contractor or PEO. Provide a detailed explanation.

10. Provide a list of all entities with which you have agreements, such as a Vendor Manager, Manage Service Provider, Manage Service agreements.

11. Describe any payroll services, HR outsourcing services or HR functions that you provide to your clients.

12. Describe any roll-over or Employer of Record (EOR) services you currently or plan to provide to your clients.

13. Do you provide the majority or all of the labor for a segment of a client's operation? Yes No If Yes, please describe.

14. In addition to staffing services, describe any other types of placements or services you provide to your clients.

15. List the names of all independent contractors (1099s) you have and/or supply to your clients. (Rare) Provide documentation for each independent contractor supporting their independent status for review.

PERSONNEL PRACTICES – Do you require or provide the following for all employees, including the employees provided to clients? If yes, provide details:

1. Pre-employment physicals	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Pre-placement drug screening	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Periodic drug testing	Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. Criminal background checks	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Motor vehicle checks on drivers	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. Job experience & certification requirements	Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Minimum experience requirements	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. New-hire orientation program	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Employee handbook	Yes <input type="checkbox"/> No <input type="checkbox"/>	
10. Performance appraisals	Yes <input type="checkbox"/> No <input type="checkbox"/>	
11. Wellness program in place	Yes <input type="checkbox"/> No <input type="checkbox"/>	

EMPLOYEE BENEFITS – Please include details in Comments section for all Yes responses.

Do you offer the following benefits to your direct employees?		% of Employer Contribution	% of Employees Enrolled	Comments
1. Medical	Yes <input type="checkbox"/> No <input type="checkbox"/>			
2. Dental	Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>			
4. Retirement	Yes <input type="checkbox"/> No <input type="checkbox"/>			
5. Paid vacation days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments		
6. Paid sick days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments		
Do you offer the following benefits to the employees you send to clients?		% of Employer Contribution	% of Employees Enrolled	Comments
7. Medical	Yes <input type="checkbox"/> No <input type="checkbox"/>			
8. Dental	Yes <input type="checkbox"/> No <input type="checkbox"/>			
9. Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>			
10. Retirement	Yes <input type="checkbox"/> No <input type="checkbox"/>			
11. Paid vacation days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments		
12. Paid sick days	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments		

CLIENT SCREENING – Please provide details in Comments section for all responses.

	Comments
1. Describe your criteria for new client selection	
2. Describe how job hazard assessments are completed for all new clients or new tasks?	
3. Do you have procedures in place to terminate clients for poor safety practices or loss experience? If so, please describe.	

4. Who reviews a client’s new worker orientation procedure?	
5. Who reviews a client’s response procedures for emergency or accidents?	
6. Do you inspect worksite for safety “prior” to employee placement as well as ongoing unannounced inspections?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Are description of the job assignment provided to the employees?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Who is responsible to provide safety training?	

SAFETY PRACTICES/PROGRAMS – Please provide details in Comments section for all Yes responses.

	Comments	
1. Do you have an IIPP in place?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2. Do you have a full time safety director? (If yes, provide name and title.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Who is responsible for accident investigations?		
4. Are your supervisors held accountable for safety at client worksites?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. Who is responsible for providing employees with PPE?		
6. Who is responsible for conducting employee safety meetings? How often are meetings held?		
7. Do you have an employee safety incentive program?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Do you offer modified duty/early return to work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Do you route claims through the carrier Medical Provider Network?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
10. Please list all safety trainings or programs offered to employees.		

Is there any other information about your company, operations, or practices that have been implemented, which may have a positive impact on employee safety?

Additional Comments

State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants. Insurance Code 11880 prohibits the willful misrepresentation of any facts in order to obtain lower insurance rates.

I have read the above and acknowledge that this is an evaluation form, **not an application for insurance, and does not bind State Fund to coverage of the above-described risk.**

Applicant’s Signature

Applicant’s Name (please print)

Date