

Towing - 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>Hours of operations: _____ am _____ pm <input type="checkbox"/> 24 hours</p> <p>Any driving in excess of 11 hours per shift? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Any driving in excess of 60 hours within 7-consecutive days? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Total number of vehicle recoveries in the last 12 months by employees: _____</p> <p>Any contract towing? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes – Please explain and provide the list of contracts:</p> <div style="border: 1px solid black; height: 60px; margin-top: 5px;">[Text Here]</div> <p>Contracts require a specific response time? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please provide response time: _____</p>	<p>Does the insured perform any of the following?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Vehicle repossession</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Recovery of vehicles transporting hazardous materials</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Repelling on hillsides/cliffs/canyons to retrieve vehicles</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Underwater recovery</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Low-bed/heavy hauling/transportation of large items such as construction equipment, farm equipment, oversized loads or aircraft?</p> <p>Percentage of towing that are from highways/freeways? _____%</p> <p>What percentage of towing is private property impounding? _____%</p> <p>(Total must equal 100%)</p> <p>1. What percentage of the insured’s operations involves towing of trucks that are one ton or greater; i.e. <i>buses, RV’s or trailers</i>? _____%</p> <p>2. What percentage involves the towing of vehicles that are less than one ton? _____%</p>
<p>Formal vehicle maintenance program in place? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, who performs the maintenance?</p> <p><input type="checkbox"/> Employees <input type="checkbox"/> Other: _____ or <input type="checkbox"/> Both</p> <p>Please describe the types of repairs maintained by employees:</p> <div style="border: 1px solid black; height: 60px; margin-top: 5px;">[Text Here]</div>	<p>Percentage of work sub-contracted out: _____%</p> <p>Are certificates collected annually for sub-contractors?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Total number of vehicle recoveries in the last 12 months by Independent contractors: _____</p> <p>Please explain the type of work sub-contracted out:</p> <div style="border: 1px solid black; height: 30px; margin-top: 5px;">[text here]</div>

General Classification Evaluation:

- 1) Maximum Height exposure: _____ Ft. N/A
If applicable - Method of reaching height exposures: _____

- 2) Maximum Weight lifted: _____ lbs. N/A
If applicable: Manual Lifting Please list the typical types of items lifted: _____
Employee(s) lifts with assistance: Please explain: _____

- 3) Vehicle exposure:

Total # of Tow Trucks: _____	Number of employee drivers: _____
Do employees take the vehicle home overnight? Yes <input type="checkbox"/> No <input type="checkbox"/>	GPS tracking system installed? Yes <input type="checkbox"/> No <input type="checkbox"/>
Driving Radius in miles: _____mi.	Company Owned: Yes <input type="checkbox"/> No <input type="checkbox"/>
MVR’s Checked: Yes <input type="checkbox"/> No <input type="checkbox"/>	MCP Filing: N/A <input type="checkbox"/> Yes: _____
PUC Filing: N/A <input type="checkbox"/> Yes: _____	

- 4) Any Out of State, International, or Overnight Travel: Yes No
If Yes - Please provide:
Number of employee’s traveling: _____ Frequency of travel: _____
Method of transportation: _____ Location(s)/State(s): _____

- 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: \$ _____
 - 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) 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 have 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]