

Agriculture / Farming - 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>Business operations include:</p> <p><input type="checkbox"/> Custom Harvester <input type="checkbox"/> Grower <input type="checkbox"/> Packer</p> <p><input type="checkbox"/> Labor Contractor <input type="checkbox"/> Other: _____</p> <p>Please select all that apply:</p> <p><input type="checkbox"/> Alfalfa/Hay/Cereal Grains <input type="checkbox"/> Citrus</p> <p><input type="checkbox"/> Cotton <input type="checkbox"/> Dairy Farm</p> <p><input type="checkbox"/> Deciduous fruit <input type="checkbox"/> Livestock</p> <p><input type="checkbox"/> Melons/pumpkins <input type="checkbox"/> Nut crops</p> <p><input type="checkbox"/> Potatoes/Sugar Beets <input type="checkbox"/> Strawberries/Bush berries</p> <p><input type="checkbox"/> Truck Farm <input type="checkbox"/> Vineyard</p> <p><input type="checkbox"/> Other: _____</p>	<p>Farm Operations:</p> <p>Manually Harvested ___%</p> <p>Mechanical Harvesting ___%</p> <p>Harvested by Others ___%</p> <p>Total: 100%</p> <p>Are pruning operations performed by employees? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Any crop dusting operations? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Any crops/orchards located on hillsides or slopes? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Pesticides/Fertilizers are applied by:</p> <p>Employees: <input type="checkbox"/> Outside Vendor: <input type="checkbox"/></p>
<p>If the business operates a Dairy Farm, please answer the following, or check: <input type="checkbox"/> My business does not operate a dairy farm.</p> <p>Size of dairy herd: _____</p> <p>Does risk grow own feed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Milking barn is: Flat <input type="checkbox"/> Elevated <input type="checkbox"/></p> <p>Average # of milking's per day: _____</p> <p>Are proper safety procedures in place for near stem pipes, lagoons or sump pumps? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p>	<p>Vehicle exposure: N/A <input type="checkbox"/> If applicable, please answer the following;</p> <p>Group transportation? No <input type="checkbox"/> Yes: Avg. # of employees per vehicle: _____</p> <p>Please explain reason for group transportation: _____</p> <p>Does the risk deliver any products? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Total # of Vehicles: _____ Number of employee drivers: _____</p> <p>Do employees take the vehicle home overnight? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Radius in miles: _____mi. GPS tracking system installed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>MVR's Checked: Yes <input type="checkbox"/> No <input type="checkbox"/> Company Owned Vehicles: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>PUC Filing: N/A <input type="checkbox"/> Yes: _____ MCP Filing: N/A <input type="checkbox"/> Yes: _____</p>
<p>Is housing provided? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, # of employees who are provided with housing: _____</p> <p>Are ATV's used? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, how many ATV's are used? _____</p>	<p>Are any of the employees relatives of the business owner: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Number of employees who are relatives: _____</p> <p>If yes: Are the relatives included in the payroll estimates? Yes <input type="checkbox"/> No <input type="checkbox"/></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? Yes No

- 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) Any Out of State, International, or Overnight Travel: No If Yes, please provide the following:
 Number of employee's traveling: _____
 Method of transportation: _____ Location(s): _____
 Frequency of travel: _____

- 4) 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 a 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) Extreme temperature program meets Cal OSHA Requirements: Yes No N/A
- 4) Respiratory program: Yes No N/A
- 5) Driver safety training plan: Yes No N/A
- 6) Forklift training & safety plan: Yes No N/A
 - If Yes – Annual Certification required:** Yes No N/A
- 7) MSDS available for all chemicals/products used: Yes No N/A
- 8) Written Lockout/Tag out/Block out Procedures: Yes No N/A
- 9) Hazardous chemicals safety plan: Yes No N/A
- 10) Confined spaces plan: Yes No N/A
- 11) Active safety incentive program for all employees: Yes No N/A
- 12) Are supervisors held accountable for a safe work environment? 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 provide 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]