# workers’ compensation supplemental QUESTIONNAIRE

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TO | |  | | | | | | | | | DATE | | |  | | |
| SUBMITTED BY | |  | | | | | | | | | | | | | | |
| ACORD Application must be fully complete including number of full-time and part-time employees by class. | | | | | | | | | | | | | | | | |
| Include a loss summary that includes payroll, premium, and loss history for the last five years. | | | | | | | | | | | | | | | | |
|  | | | |  | | |  | | | | | |  | | | |
| 1. ACCOUNT |  | | | | | | | | |  | | | | |  | |
| Named Insured: | | | | | | | | | | | | | | | | |
| Hours of Operation | |  | | | | | | # of Shifts | | |  | | | | | |
| Affiliated Trade or Safety Organizations | | | | | | | |  | | | | | | | | |
| Union | | | Non-Union | | If Union, Employees Participating | | | | | | | % | | | | |
|  | | | |  | | |  | | | | | |  | | | |
| PAYROLLS AND PREMIUMS | | | | | | | | | | | | | | | | |
| Historical | | | | | | Total Payroll | | | | | | | | | | Premium |
| 2017 | | | | | | $ | | | | | | | | | | $ |
| 2016 | | | | | | $ | | | | | | | | | | $ |
| 2015 | | | | | | $ | | | | | | | | | | $ |
| 2014 | | | | | | $ | | | | | | | | | | $ |
| 2013 | | | | | | $ | | | | | | | | | | $ |
| Current | | | | | | Low | | | Average | | | | | | | High |
| Full-Time employee wage scale | | | | | | $ | | | $ | | | | | | | $ |
| Part-Time employee wage scale | | | | | | $ | | | $ | | | | | | | $ |
| Any volunteers | | | | | | Yes  No | | | If yes, # of: | | | | | | | |
| Any seasonal employees | | | | | | Yes  No | | | If yes, # of: | | | | | | | |
| Are temporary employees utilized | | | | | | Yes  No | | |  | | | | | | | |
| If yes, in what capacity | | | | | |  | | | | | | | | | | |
| Are any employees paid based on piecework | | | | | | Yes  No | | | If yes, # of: | | | | | | | |
| If yes, who | | | | | |  | | | | | | | | | | |

# workers’ compensation supplemental QUESTIONNAIRE (continued)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| BENEFITS |  | | | | | |  | |  | | |
| Medical Benefits | | | | | | | Other Benefits | | | | |
| Provided | | | | Yes  No | | | Dental | | | Yes  No | |
| For which Employees | | | |  | | | Vacation | | | Yes  No | |
| % Funded by Employer | | | | % | | | Paid Sick Leave Plan | | | Yes  No | |
| % of Participation | | | | % | | | Disability | | | Yes  No | |
| Waiting Period | | | |  | | | Drug / Alcohol Rehab Program | | | Yes  No | |
| Health Coverage Carrier | | | | | | | Retirement / Pension Plan | | | Yes  No | |
| Employer Contribution | | | Yes  No | |
|  | | | | |  | |  | | | |  | |
| HIRING PRACTICES | | | | |  | |  | | |  | |
| Employment Interviews Conducted by | | | Human Resources  Department Managers   Supervisors  Upper Management | | | | | | | | |
| Written Disciplinary Procedure in Place | | | Yes  No | | | | | | | | |
| Pre-Hiring Physicals | | | Yes  No | | | | | | | | |
| Back X-Ray Screening | | | Yes  No | | | | | | | | |
| Annual Physicals / New Hires | | | Yes  No | | | | | | | | |
| Pre-Hiring Drug Testing | | | Yes  No | | | | | | | | |
| All References Checked | | | Yes  No | | | | | | | | |
|  | |  | | | | |  | | | |  | |
| TURNOVER | | | | | | | | | | | |
| Are # of employees | | | | Increasing  Decreasing  Stable | | | | | | | |
| Turnover % in last 12 months | | | | Full Time | | % | | Part Time | | % | |
|  | |  | | | |  | | | | |  | |
| LOSS CONTROL / SAFETY PROGRAM | | | | | | | | | | | |
| Is there a Risk Manager or Safety Director | | | | | | | Yes  No | | | | |
| Loss Control / Safety Program | | | | | | | Yes  No | Start Date | |  | |
| Frequency of Meetings | | | | | | | Weekly  Monthly  Other | | | | |
| Mandatory Attendance for all Employees | | | | | | | Yes  No | | | | |

# workers’ compensation supplemental questionnaire (continued)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LOSS CONTROL / SAFETY PROGRAM (continued) | | | | | | |  | | |
| Supervisor Compensation based in-part on Safety Record | | | | Yes  No | How |  | | | |
| Loss Control Incentive Program | | | | Yes  No | | | | | |
| Describe |  | | | | | | | | |
| Any OSHA violations in the past 3 years | | | | Yes  No | | | | | |
| Any open citations | | | | Yes  No | | | | | |
| If yes, how are they addressing the recommendation | | | |  | | | | | |
| Return to Work Program: Modified / Alternate Work Offered | | | | Yes  No | Salary Continuation | | | | Yes  No |
| Formal Accident Investigation | | | | Yes  No | | | | | |
| Post Accident Drug Testing | | | | Yes  No | | | | | |
| Personal Protective Equipment provided | | | | Yes  No | | | | | |
| Describe |  | | | | | | | | |
|  | |  |  | | | | |  | | |
| TRAINING | | | | | | | | | |
| Safety Orientation included | | | | Yes  No | | | | | |
| Type of Training | | | | | | | | | |
| Lifting Exposure (Unassisted) | | | | Little or None  20 or fewer lbs.  20 to 50 lbs.  Over 50 lbs. | | | | | |
| SB 198 Program with Full Compliance | | | | Yes  No | | | | | |
| Existence of Hazard Identification and Correction Procedures | | | | Yes  No | | | | | |
| Emergency Evacuation Procedures | | | | Yes  No | | | | | |
| Evacuation Drills Held | | | | Yes  No | | | | | |
| CPR training for any employees | | | | Yes  No | | | | | |
| Describe |  | | | | | | | | |
|  | |  |  | | | | |  | | |
| MEDICAL CLINIC(S) USED FOR WORKERS’ COMPENSATION CLAIMS | | | | | | |  | | |
| Clinic Name | | | | Location | | | | | |
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# workers’ compensation supplemental questionnaire (continued)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| VEHICLE | | | | | | | | | | | | |
| # Private Passenger Vehicles | | |  | | | # Commercial Vehicles |  | | | # Drivers |  | |
| MVRS checked on all drivers | | | Yes  No | | | Frequency? |  | | | | | |
| Personal vehicles used for company business | | | Yes  No | | | Delivery Exposure | Yes  No | | | Frequency? |  | |
| Radius of Operations | | | < 50 miles  50-100 miles  > 100 miles | | | | | | | | | |
| Employee transportation provided | | | Yes  No | | | Max # of employees | | | |  | | |
| Mode of transportation | | |  | | | | | | | | | |
| Vehicle maintenance program | | | Yes  No | | |  | | | | | | |
| Who services | | | In-house  Outside Vendor  Other | | | | | | | | | |
| Are company owned vehicles taken home | | | Yes  No | | | If so, # Vehicles |  | | | # Drivers |  | |
|  |  | | | |  | | |  | | | |
| TRAVEL | |  | | | |  | | | | | | |
| Travel required for employees | | | Yes  No | | | If yes, percentage of | | | | % | | |
| Length of average trip | | |  | | | | | | | | | |
| International travel required | | | Yes  No | | | If yes, where | | | |  | | |
| Any employees based out of state | | | Yes  No | | | If yes, where | | | |  | | |
|  |  | | | |  | | | | |  | |
| SOURCE OF INFORMATION | |  | |  | | | | |  | | | |
| Applicant’s Signature  (MUST be Officer, Owner or Partner) | | |  | | | | | | | | | |
| Date | | |  | | | | | | | | | |

# WORKERS’ COMPENSATION – EMPLOYEE CONCENTRATION WORKSHEET

The Employee Concentration information requested below is required by a number of Workers Compensation insurance carriers due to mandates by certain states for proof of coverage reporting. The request for number of employees is not used for rating purposes, but it is required information in addition to any Workers Compensation application or questionnaire.

* Named Insureds must have a corresponding Federal Employer ID # (FEIN) and State Unemployment ID # (UI) per state location.
* For this report, there is no distinction between full-time and part-time employees. Part-time employees should be counted as full-time.
* This form must be received with submission. Any format is acceptable providing criteria listed below is included.

|  |  |  |  |
| --- | --- | --- | --- |
| NAMED INSURED  (List All Names) | STATE | FEIN and UI | LOCATION #  (MUST correspond to Location # listed on next page) |
|  |  | FEIN:  UI: |  |
|  |  | FEIN:  UI: |  |
|  |  | FEIN:  UI: |  |
|  |  | FEIN:  UI: |  |
|  |  | FEIN:  UI: |  |
|  |  | FEIN:  UI: |  |

# EMPLOYEE CONCENTRATION / CATASTROPHE / TERRORISM

**NAMED INSURED:**

If Less Than 10 Employees

If Greater Than 10 Employees

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LOCATION #  (#’s must correspond to Location # listed on Previous Page) | STREET ADDRESS | CITY | STATE | ZIP | TOTAL # OF EMPLOYEES  (Full and Part-Time) | MAX # EMPLOYEES  ANY ONE TIME  AT LOCATION | # OF STORIES | IF GREATER THAN 10 STORIES – HIGHEST FLOOR OCCUPIED | CONSTRUCTION TYPE | YEAR BUILT | BUILDING SPRINKLERED?  (Y/N) |
|  |  |  |  |  |  |  |  |  |  |  |  |
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List all annual or regular business meetings, trade shows, conventions, training or other company events where 20 or more employees attend:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DATE | MEETING TYPE | LOCATION NAME | CITY | STATE OR COUNTRY | # EMPLOYEES ATTENDING |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |