# workers’ compensation supplemental QUESTIONNAIRE

|  |  |  |  |
| --- | --- | --- | --- |
| 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)

|  |  |
| --- | --- |
| 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 |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |

# workers’ compensation supplemental questionnaire (continued)

|  |
| --- |
| 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) |
|       |        |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |       |       |       |

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 |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |