



Insured: \_\_\_\_\_ Eff Date: \_\_\_\_\_ FEIN NO. \_\_\_\_\_

Contact Name & Title: \_\_\_\_\_ Tel. No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

**INSURED HISTORY:**

Years in business: \_\_\_\_\_ if less than 5 number of years in trade \_\_\_\_\_ No. of locations \_\_\_\_\_

Description of Operations \_\_\_\_\_

Out of state exposure:  Yes  No If yes, name of states: \_\_\_\_\_ Foreign Travel:  Yes  No

Present number of employees: Full-time employees \_\_\_\_\_ Part-time \_\_\_\_\_ Seasonal \_\_\_\_\_ Volunteers \_\_\_\_\_

Percent of employee turnover in the last 12 months Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Employee staffing expectation over the next 12 months Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Average hourly wage: Full-time \$ \_\_\_\_\_ Part-time \$ \_\_\_\_\_ Any Piece work compensation: \_\_\_\_\_

Benefits provided – are ALL employees eligible  Yes  No If not then who is eligible? \_\_\_\_\_

**% paid by employer** **% of participation**

Group Health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
Paid sick leave	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
Vacation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____
Retirement / Pension Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____

Name of Healthcare provider: \_\_\_\_\_

Provide name of clinic, physician, or emergency room used for work place related injury: \_\_\_\_\_

Full-time nurse maintained on staff:  Yes  No

CPR training provided  Yes  No

**Indicate the safety activities currently established and practiced regularly:**

Is Owner active in daily operations  Yes  No, if yes duties performed: \_\_\_\_\_

Safety program / IIPP in use compliant with SB 198  Yes  No

Return to light duty plan  Yes  No Includes full wages  Yes  No

Return to Full-time modified work plan  Yes  No

Designated Full-time safety director  Yes  No Name: \_\_\_\_\_

Safety meetings held for all employees  Yes  No Frequency of meetings \_\_\_\_\_

Safety training held for all employees  Yes  No Incentive program for employees  Yes  No

Slip and Fall Prevention Program in place  Yes  No

Hazardous Materials Communication program in place  Yes  No

Personal Protective safety equipment provided for all employees  Yes  No If yes, what type: \_\_\_\_\_

Supervisors are held accountable for injuries / accidents  Yes  No

Accident investigation program in place  Yes  No

**HIRING PRACTICES:**

Employment application	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drug/substance abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reference checks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Audiometric testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Motor Vehicle Record check	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pre/Post employment physical	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Volunteer labor used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pathogenic test (i.e. lead)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Temporary labor used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthopedic back test	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**OPERATIONS:**

Hours of operation: \_\_\_\_\_ to \_\_\_\_\_ No. of daily shifts: \_\_\_\_\_ No. of days per week: \_\_\_\_\_  
 Operation includes delivery  Yes  No No. of authorized drivers \_\_\_\_\_ No. of vehicles \_\_\_\_\_  
 Frequency of delivery: Daily  Weekly  Other  \_\_\_\_\_  
 Delivery radius: < 50 miles  51-100 miles  101-250 miles  >250 miles   
 Frequency of MVR checks \_\_\_\_\_ Participation in CHP Pull program  Yes  No  
 Driver acceptability standards have been established  Yes  No  
 Vehicle inspection / maintenance program  Yes  No Frequency \_\_\_\_\_  
 Vehicle maintenance is performed by employees  Yes  No  
 Employees take vehicles home at night  Yes  No

**PAYROLL AND PREMIUM HISTORY:**

Payroll : Current Yr. \_\_\_\_\_ Premium: Current Yr. \_\_\_\_\_  
 1<sup>st</sup> Prior Yr. \_\_\_\_\_ 1<sup>st</sup> Prior Yr. \_\_\_\_\_  
 2<sup>nd</sup> Prior Yr. \_\_\_\_\_ 2<sup>nd</sup> Prior Yr. \_\_\_\_\_  
 3<sup>rd</sup> Prior Yr. \_\_\_\_\_ 3<sup>rd</sup> Prior Yr. \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\*THIS FORM MUST BE FILLED OUT IF IT APPLIES TO THE INSURED\*\*\***

**CONTRACTORS:**

Contractors License Number: \_\_\_\_\_

Percentage of new construction: Residential \_\_\_\_\_% Commercial \_\_\_\_\_% Industrial \_\_\_\_\_%  
 Percentage of remodeling: Residential \_\_\_\_\_% Commercial \_\_\_\_\_% Industrial \_\_\_\_\_%  
 Percentage of repair work: Residential \_\_\_\_\_% Commercial \_\_\_\_\_% Industrial \_\_\_\_\_%  
 Percentage of work subcontracted: \_\_\_\_\_%  
 Any work performed above 2 stories:  Yes  No If yes, explain \_\_\_\_\_  
 Any Roof Exposure:  Yes  No If yes, explain \_\_\_\_\_  
 Details of Interior and/or Exterior work performed \_\_\_\_\_  
 Any use of Cranes:  Yes  No If yes, explain \_\_\_\_\_  
 Any use of Scaffolds:  Yes  No If yes, are the ee's certified? \_\_\_\_\_  
 Any Excavation exposure:  Yes  No If yes, explain depth \_\_\_\_\_  
 Are deliveries made:  Yes  No Frequency: Daily  Weekly  Other: \_\_\_\_\_  
 Delivery radius: Under 50 miles  50-100 miles  Over 100 miles   
 Vehicles owned:  Yes  No If yes, take home:  Yes  No  
 Vehicle maintenance program:  Yes  No  
 MVR "Pull" program:  Yes  No If yes, how often \_\_\_\_\_  
 Any changes in operations in the last 5 years:  Yes  No If yes, describe: \_\_\_\_\_  
 Condition of equipment: Excellent  Good  Poor   
 Any job site security provided:  Yes  No If yes, describe: \_\_\_\_\_

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**HOTEL / MOTEL:**

Number of guest rooms: \_\_\_\_\_ Room rate: Under \$50  \$50-74.95  \$75-99  Over \$100   
Food service: Operate own:  Yes  No Subcontract: Restaurant  Bar  Both   
Gross receipts: Food \_\_\_\_\_% Liquor \_\_\_\_\_%  
Entertainment:  Yes  No Lounge:  Yes  No Armed Security:  Yes  No  
Operation: Year round  Seasonal  Conference center:  Yes  No  
Shuttle service:  Yes  No How many vans: \_\_\_\_\_  
How are maids compensated: Salary  Hourly wage  Flat rate per room   
Who flips the mattresses and how are they turned: \_\_\_\_\_

**RETAIL / WHOLESALE:**

Gross receipts: Wholesale \_\_\_\_\_% Retail \_\_\_\_\_%  
Compensation: Flat salary \_\_\_\_\_ Hourly wage \_\_\_\_\_ Type of merchandise: \_\_\_\_\_  
Outside sales employees:  Yes  No Commission \_\_\_\_\_  
Lifting exposure or repackaging:  Yes  No Lbs: \_\_\_\_\_ Is there assembly:  Yes  No  
If yes, describe? \_\_\_\_\_

**MANUFACTURING:**

Machine guarding: Point of operation:  Yes  No Drive mechanism:  Yes  No Moving Parts:  Yes  No  
Computer operated equipment:  Yes  No  
Material handling exposure:  Yes  No Lifting:  Below 50 lbs.  Above 50 lbs. \_\_\_\_\_  
Off premises operations:  Yes  No Percentage \_\_\_\_\_ Where / What: \_\_\_\_\_

TYPE OF MACHINES USED? \_\_\_\_\_

**SERVICE STATIONS / AUTO REPAIR SHOPS / TRANSMISSION SHOPS:**

Hours of Operation \_\_\_\_\_ Mini-Market:  Yes  No Liquor sold?  Yes  No  
Gas operation:  Full Service  Self service Bullet proof cashier booth:  Yes  No  
Repair operation:  Yes  No Drop safe or registers:  Yes  No  
 Tire repair/installation :  Split Rim  Over 1-ton truck Car Wash:  Yes  No If yes,  self serve  full serve  
Towing:  Yes  No Contract tow:  Yes  No Access to freeway:  0-1 mile  1-2 miles  2+ miles

**ATTORNEYS:**

What type of law: \_\_\_\_\_  
Any criminal law:  Yes  No  
Any insurance law:  Yes  No

**RESTAURANT:**

Average Entrée Price: \_\_\_\_\_ Take-out:  Yes  No % of revenues \_\_\_\_\_  
Liquor Receipts (% of gross receipts) \_\_\_\_\_ Catering  Yes  No % of revenues \_\_\_\_\_  
Separate Lounge:  Yes  No Delivery  Yes  No % of revenues \_\_\_\_\_  
Twenty-four hour operation:  Yes  No Valet Parking  Yes  No  
Number of: Hosts \_\_\_\_\_ Wait-staff \_\_\_\_\_ Cooks \_\_\_\_\_  
Bartenders \_\_\_\_\_ Radius of delivery area \_\_\_\_\_  
Entertainment:  Yes  No If yes, please provide details: \_\_\_\_\_

**APARTMENT OWNER OR OPERATOR:**

List of operations sub-contracted to others: \_\_\_\_\_  
Any tenants perform sub-contracted operations for you?  Yes  No If yes, please list: \_\_\_\_\_  
The following items are maintained and kept current for all sub-contractors:  
Certificate of workers' compensation insurance  Yes  No  
Copy of each sub-contractor's license number  Yes  No  
List of current sub-contractors and contractor's license numbers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(If more than 3 provide a separate list)