

# CIMS -- STATE FUND SUPPLEMENTAL QUESTIONNAIRE

Trade/DBA Name: \_\_\_\_\_

Legal Name: \_\_\_\_\_

## General Information:

**YES NO Do any of the following pertain to the operations of this risk? If yes, please explain.**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Use any equipment that bends, forms, shapes or cuts materials (eg, power press)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Employ any relatives?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Employ any minors (under age 18)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Make any cash payments to employees or subcontractors?                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Provide meals or lodging in lieu of wages?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Pay any employees by the piece?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any work at a maritime or offshore facility?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any locations/operations for which coverage is not requested?               |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any operations outside of California?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Perform any asbestos removal?  |

**Has the business or any principal of the business declared bankruptcy in the last 7 years?**

Yes  No

**If yes, what is the status?**  Pending  Dismissed  Discharged

**Was this operation all or part of an existing business that was purchased or acquired?** Yes  No

*If yes, please provide a copy of your bill of sale.*

## Management Practices

**Do you offer?**

- Yes  No  **Employee Assistance Program**  
Yes  No  **Paid Vacations**  
Yes  No  **Paid Sick Leave**

**Do you offer the majority of your eligible employees health insurance (eligible=30 hrs a week or more)?**

Yes  No

**If yes, do you pay at least 50% of the health insurance premium** Yes  No

**Name of Health Insurance Carrier:** \_\_\_\_\_

**Please check off the hiring practices implemented by your company:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Job Descriptions    | <input type="checkbox"/> Pre-Placement Medical Screening | <input type="checkbox"/> Pre-Placement Drug Testing |
| <input type="checkbox"/> Drug-Free Workplace | <input type="checkbox"/> Pre-Employment Reference Check  | <input type="checkbox"/> Union Employees            |

Yes  No  **Do you have an Injury & Illness Prevention Program (SB-198)?**

Yes  No  **Do you have a written early return-to-work program for employees injured on the job?**

Yes  No  **Have you received any OSHA citations within the past year?**

**Do you document:**

Employee Training Yes  No

Facility Inspections Yes  No

**Describe your housekeeping:**  Good  Fair  Poor

**Describe the condition of your equipment:**  Good  Fair  Poor