

Named Insured: \_\_\_\_\_ App/Pol # \_\_\_\_\_ Eff Date: \_\_\_\_\_  
Agent/Broker: \_\_\_\_\_ Contact: J. MASON (CIMS) Fax: 800-210-3210  
Undr: \_\_\_\_\_ Phone: (805) 376- Fax: (805) 499-7214

### A. Insured History

- Does the insured provide any medical benefits to their employees?  Yes  No  
If so, what percentage of the medical premium does the employer pay? \_\_\_\_\_ %  
Percentage of employees participating in the Group Health Plan: \_\_\_\_\_ %  
Who is eligible?  Full-time employees  Part-time employees  Seasonal  Mgr/Supv Only  
Provider: \_\_\_\_\_ Other benefits: \_\_\_\_\_
- Do the employees get a paid vacation?  Yes  No Paid Sick Leave?  Yes  No
- Employee turnover per year? \_\_\_\_\_ %
- What is the Average Weekly Wage of the employees in the governing class? \$ \_\_\_\_\_ Per Week
- Please send us a current experience modification worksheet**
- Please send us a copy of their Bureau Inspection Report**

### B. Hiring Practices

- |                               |  |                                |  |
|-------------------------------|--|--------------------------------|--|
| Reference Checks              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Use of Background Checking Svc | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pre-Employment Drug Testing   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Post Accident Drug Testing     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Volunteer Labor used          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Temporary Labor used           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Leased Employees Used         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthopedic Back Test           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Audiometric Testing           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pathogenic Test (i.e. lead)    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| MVR's checked                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequency _____                |  |
| Subscribe to CHP pull program | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                |  |

### C. Safety Program

- |   |  |  |  |
|---|--|--|--|
| Safety Program/IIPP                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | New Employee Orientation Plan                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Safety Incentive Plan                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Written Supv Accountability Plan                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| F/T Safety Director                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hazard Communication Program                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Early Return-to-work Program                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Modified/Light Duties                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Respirator Program                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Conservation Program                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Documented Safety Meetings                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequency: _____   |  |
| Training Program                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequency: _____   |  |
| Accident Investigation Program              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Machine guarding in place?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lock-out / Tag-out?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bloodborne Pathogens Program                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| MSDS Posted Properly                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Documented Physical Inspection of premises? |  | List mechanical lifting devices used: _____              |  |
| Maximum weight lifted manually _____ lbs    |  | Describe Ergonomic Safety Features: _____                |  |
| List mechanical lifting devices used: _____ |  |  |  |
- Forklifts used on premises?  Yes  No If yes, advise:  
# of Forklifts? \_\_\_\_\_ # of Drivers? \_\_\_\_\_ Training provided?  Yes  No Certified?  Yes  No

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Personal protection equipment provided?  Yes  No Mandatory?  Yes  No  
 Back Belts  Goggles  Masks  Face Guard  Gloves  
 Hearing Protection Devices  Respirators Other: \_\_\_\_\_

### D. Insured Operations

1. Hours of operation: \_\_\_\_\_ AM TO \_\_\_\_\_ PM Any weekend, nightshifts or graveyard shifts?  Yes  No
2. Operations include delivery?  Yes  No # of Vehicles: \_\_\_\_\_ # of Drivers: \_\_\_\_\_  
Radius of Delivery?  < 50 mi  51-100 mi  101-250 mi  250 mi  
Frequency of Deliveries?  Daily  Weekly  Other: \_\_\_\_\_
3. Is there a vehicle inspection/maintenance program?  Yes  No
4. Has a driver acceptability standard been established?  Yes  No
5. Do employees take vehicles home?  Yes  No
6. Are there any off-premise operations?  Yes  No If yes, advise: \_\_\_\_\_ % Explain duties: \_\_\_\_\_
7. Any employees working out of their home?  Yes  No If yes, explain: \_\_\_\_\_
8. Any interchange of employees?  Yes  No If yes, explain: \_\_\_\_\_
9. Are employees permitted to use personal vehicles for errands/deliveries?  Yes  No
10. Employees permitted to use motorcycles for delivery purposes?  Yes  No
11. Any out-of state traveling?  Yes  No Any Foreign traveling?  Yes  No  
Describe operations outside of California: \_\_\_\_\_  
Destination \_\_\_\_\_ Duration \_\_\_\_\_ # of employees: \_\_\_\_\_ Frequency \_\_\_\_\_  
Mode of Transportation \_\_\_\_\_  
**If foreign travel:** Is there Foreign Coverage?  Yes  No **Provide a copy of the dec page**
12. Any employees residing outside of California?  Yes  No # of Employees \_\_\_\_\_ What states? \_\_\_\_\_  
Is there coverage?  Yes  No **Provide a copy of the carrier's declaration page**

### E. Employee & Payroll Trends:

- A. Future Staff Increases: \_\_\_\_\_ Future Staff Decreases: \_\_\_\_\_  
B. Future Layoffs Foreseen:  Yes  No

### F. Management:

- A. Owners: Active in Management:  Yes  No  
Absentee:  Yes  No
- B. Trade Associations: \_\_\_\_\_
- C. Group Transportation Provided:  Yes  No
- D. Ratio of Supervisors to Employees: \_\_\_\_\_  
Average number of years experience: \_\_\_\_\_  
Average number of years with Company: \_\_\_\_\_

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**D. Claims: Please forward at least 4 years of loss information valued within 90 days of the policy inception:**

For all claims over \$25,000 please advise the following:

Was it an accepted claim?

What was the injury?

How did it occur?

Is the employee still working for the insured?

What corrective action has the insured taken to prevent recurrence?

**E. Premium/Payrolls: Provide final audited premium/payroll for accounts with premiums over \$50,000+**

		<u>PREMIUM</u>	<u>PAYROLL</u>
2006 to 2007	Est	\$ _____	\$ _____
2005 to 2006		\$ _____	\$ _____
2004 to 2005		\$ _____	\$ _____
2003 to 2004		\$ _____	\$ _____
2002 to 2003		\$ _____	\$ _____
2001 to 2002		\$ _____	\$ _____

Insured's Website Address: \_\_\_\_\_

Additional Information/Comments:

\_\_\_\_\_

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