

Named Insured: _____ Phone: _____
 Mailing Address: _____ Fax: _____
 Location Address: _____ Contact Name: _____
 _____ Best Time to Contact: _____

PLEASE COMPLETE THE FOLLOWING TO ASSIST US IN PROVIDING OUR MOST COMPETITIVE INSURANCE QUOTATION:

Description of Operations: _____

Employee Benefits

Medical Insurance Provided? _____ Amount Paid by Employer? _____
 Employer Paid Vacation ? _____ Employer Paid Sick Leave? _____

Employee Management

Pre-Hire Screening
 Applications: [] Yes [] No
 Reference Checks: [] Yes [] No
 Physicals: [] Yes [] No
 Pre-Hire Drug Test: [] Yes [] No
 Other Elements of Drug Testing Program:
 Random: [] Yes [] No
 Post-Accident: [] Yes [] No
 Baseline: [] Yes [] No

Employee and Payroll Trends

Future staff increases or decreases? _____
 Future Layoffs Foreseen? [] Yes [] No

Employee Profile

Union? [] Yes [] No
 Number of W2's filed for last reporting period: _____
 Starting Wage per Hour: \$ _____
 Average Wage per Hour: \$ _____
 # Permanent Employees: _____ # Full Time _____ # Part Time _____
 # Temp/Seasonal Employees: _____
 Average # of Years with Company: _____
 Ratio of Supervisors to Employees: _____
 Average # of Years Experience of Supervisors: _____
 Average # of Years Experience with Company: _____
 Is there any interchange of labor between another company or job duties that fall in separate classifications? [] Yes [] No If yes, describe.
 Percent Off-Premises Operations: _____
 No. of Company Vehicles: _____ No. of Drivers: _____
 Radius of Driving Operations: _____ MVR's checked: [] Yes [] No
 Do Employees drive their personal autos on Company Business: [] Yes [] No
 Any weekend, nightshifts, or graveyard shifts? _____
 Hours of Operation: _____

Medical Controls

Are any employees trained in first aid? [] Yes [] No
 Does your company have emergency and disaster plans? [] Yes [] No

Employee Safety Program:

New Employee Orientation Program: [] Yes [] No

Safety Training Program: [] Yes [] No

Formal Written Safety Program: [] Yes [] No

Light Duty / Early Return to Work Program: [] Yes [] No

Safety Incentive Plan: [] Yes [] No

Safety Committee: [] Yes [] No

Members of Safety Committee (Please Circle): Employees, Supervisors, Managers, Owners

Full Time Safety Director / Risk Manager: [] Yes [] No

Written Supervisor Accountability Plan: [] Yes [] No

Maximum weight lifted manually _____ lbs

Controls (back belts, forklifts): _____

Machine safety guards in place: [] Yes [] No

Describe insured's accident/incident investigation and hazard identification program including corrective action and record keeping.

Management

Owners: Active in Management: [] Yes [] No

Absentee: [] Yes [] No

Trade Associations: _____

Group Transportation Provided: [] Yes [] No

Physical Hazards

Describe type of equipment used in operations:

Describe training on equipment or certifications required:

Any unusual machinery or equipment not typically contemplated in this type of operation?

Describe housekeeping and condition of premises:

Any toxic or hazardous substances used in operations? [] Yes [] No

If yes, describe precautions taken when working with these.

Does insured have a hazardous materials identification program? [] Yes [] No

Describe ergonomic stresses, material handling or lifting exposures and precautions taken to minimize odds of injury.

What precautions are taken to minimize these hazards?

Describe any confined space entry or workspace hazards.

Any catastrophic exposures - explosions or fire exposures? [] Yes [] No

If yes, please describe.

CONTRACTOR SUPPLEMENTAL

Type of Construction:

Residential _____ %	Commercial _____ %	Industrial _____
Heavy Civil _____ %	Mining _____ %	Other _____
Framing _____ %	Remodel _____ %	Finish Work _____
Roofing _____ %	Other (Specify) _____	

Contractor License # _____

Subcontractors:

Are subcontractors used in your business? Yes No
If yes, what type of work is subcontracted?

Are certificates of insurance obtained on all work that is subcontracted? Yes No
If no, explain why.

Operations:

Describe Operations, Processes, and Equipment:

Describe any new or discontinued operations:

Describe any underground work:

Describe any work above 2 stories:

Claims:

Describe in detail, any OSHA citation(s) your company has had within the past five years, within the USA:

Additional Information/Comments:

Signature & Title _____

Date _____