

CHOMKO Insurance Services

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Workers' Compensation Supplemental Questionnaire - General

GENERAL INFORMATION

Named Insured: _____

Number of years in business: _____

Note any changes to operations in the last five years:

Are there any plans to downsize or grow the operations? Yes No

If yes, please describe including approximate time frame? _____

I. CLASS FIT

Describe the product or services being offered? _____

Is there auto exposure? Yes No If yes, complete the following:

- > Are deliveries made: Yes No
- > Number of Autos: _____ Trucks: _____
- > Frequency: Daily Weekly Other
- > Delivery radius: Under 50 miles 50-100 miles Over 100 miles
- > Vehicles owned: Yes No Are vehicles taken home: Yes No
- > Vehicle maintenance program: Yes No MVR "pull" program: Yes No

Controls

Equipment Inspection/Maintenance program: Yes No

Slip & Fall Prevention program in place: Yes No

Lock Out / Tag Out program in place: Yes No Confined Space program in place: Yes No

Violence intervention program: Yes No Hazardous Materials Communication Program: Yes No

EAP program: Yes No Post Accident Drug Testing: Yes No

First Aid Kit kept at the Jobsite: Yes No Any Employees trained in First Aid: Yes No

Any Employees trained in CPR: Yes No

Is Personal Protective Equipment used? Yes No Explain: _____

Describe safety training programs (orientation, job process, etc.)? _____

Operations

Number of shifts: _____ Days/Hours of Operation: _____

Do employees travel out of state on business: Yes No Travel abroad? Yes No

If yes, number of employees: _____ Where and how frequently? _____

Are there any company owned/leased aircraft: Yes No

Hiring Practices

Complete written applications: Yes No Reference checks: Yes No

Pre/Post employment physicals: Yes No Orthopedic back test: Yes No

Pre-Hire drug abuse tests: Yes No MVR's checked: Yes No

How are potential new employees hired? (check all that apply):

Temp Service Referrals Word of Mouth Newspaper Ads Recruiters Union Hall Other

II. WAGE INFORMATION

What is the average annual wage of the governing class of employees: \$_____

Employee Profile

Number of employees: Full Time: _____Part time: _____Seasonal: _____ Temp/Agency: _____

What is the turnover rate? _____ When are the seasonal operations, peak months? _____

What percentage of employees have been with the company less than one year? _____

Historical Payroll

Provide total payroll for the current and prior five years.

Year Payroll

	\$
	\$
	\$
	\$
	\$

III. MANAGEMENT

How many years experience do the owners have in this industry? _____ With this business? _____

Are all the owners active in the business: Yes No

Title/Duties performed: _____

Benefits

Is Group Medical provided? Yes No Employer contribution: _____%

What percentage of employees are covered by the plan: _____%

Waiting period: 30 days 60 days 90 days Other: _____ Who is eligible? All employees Only full time

Name of Group Medical provider: _____

Paid Vacation: Yes No

Paid Sick Leave: Yes No

401K Profit Sharing: Yes No

Vision: Yes No

Dental: Yes No

IV. SAFETY AND HEALTH PROGRAM

Person responsible for safety: _____ Phone # _____

Is Safety Director full time: Yes No

Written Safety Program (SB198): Yes No

Is there a return to work program: Yes No

Fully paid? Yes No

Is a specific Medical Provider used to treat injured employees: Yes No

Clinic Physician Emergency Room Other Name and city: _____

Describe safety program and explain management's accountability at all levels of the organization. _____

Describe safety meeting structure; documentation, training, and accident investigation.

Please describe safety incentive programs if provided?

V. LOSS EXPERIENCE

Provide detailed loss exhibit that shows cause of loss as well as paid and incurred amounts.

VI. FINANCIALS: Provide current income statement and balance sheet if over \$250,000 in premium.

Has the account filed for bankruptcy or recently come out of reorganization within the past three years?

REINSURANCE

Are any premises within two miles of the following building or facilities?

- | | | |
|---|------------------------------|-----------------------------|
| Government or Military base | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Financial Institutions including national/regional stock exchange | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sport Stadiums/Arenas and Theme Parks | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Major Bridges, Tunnels or Dams | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Utilities or Power Generation Plants | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Transportation Hubs, Railroads, Airports or Shipping | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Historic/Symbolic buildings, monuments or parks | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Please provide a spread sheet if more than one location and provide the following information for each location: (zip code is necessary)

Street/City/State/zip code: _____

Number of employees at this location: _____ Hours of operation: _____ # of shifts: _____

Maximum employees per shift: _____ Minimum employees per shift: _____

Type of construction: Wood Frame _____ Light Metal _____ Unreinforced Masonry _____

Reinforced Concrete _____ Steel Frame _____ Tilt Up _____ Other (Explain) _____

Seismically retrofitted? Yes No If yes, year completed: _____

Age of building: _____ Number of floors: _____ Specific floors occupied: _____

Location is: Single building: _____ Multi-building: _____ Urban: _____ Suburban: _____ Rural: _____