RateCraft

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Supplemental Questionnaire

GENERAL INFORMATION:

Company Name: ____ Contact: _________________________
Insured's Federal Tax ID Number: ___________________ State Tax ID Number:______________________
Number of years in business: ________ If less than 4 years, number of years in the trade: _____________
If this is a new business operation, what date were the employees hired? _____________________________
Is the owner active in business: **Yes No** Are they excluded? **Yes No** Duties performed: _____________
Describe operations of the insured: ____
____
Is the company currently in or has it ever filed for bankruptcy? **Yes No**
Have you purchased an existing business within the last year? **Yes No**
If yes, what percentage of employees was retained from previous owner? _______%
Has any prior insurance coverage been declined/cancelled/non-renewed in the last three years? **Yes No**
Have there been any lapses in coverage in the last three years? **Yes No**
Annual Sales: ___________________

BENEFITS:

Does insured provide group medical insurance? **Yes No** Employer contribution: _____________________
What percentage of employees is covered by the plan? _____________
Waiting period: **30 days** **60 days** **90 days** Other: ______________________________________
Name of group medical provider: ____
Who is eligible? **All Employees** **Only Full Time** **Executive Officers** **Others:**___________
What other benefits are provided:
Paid Vacation: **Yes No** Paid Sick Leave: **Yes No** 401K Profit Sharing: **Yes No**
Vision/Dental: **Yes No** Retirement: **Yes No** Stock Options: **Yes No**
Life Insurance? **Yes No** If yes, employer contribution: ______%
Disability Insurance? **Yes No** If yes, employer contribution: ______%
Do you have a Human Resources Manager? **Yes No**
Do you currently use a payroll service, such as ADP? **Yes No** If yes, who: _________________________

MANAGEMENT:

Does insured have a return to work program in place? **Yes No** With full pay? **Yes No**
Modified duty offered to injured employees? **Yes No**
Are supervisors held accountable for safety training, enforcement, and results? **Yes No**

OPERATIONS:

Hours of operation: _____ **to** _____ Number of Days per week: _______ Number of shifts: __________
Percentage of work subcontracted: _______ What kind of work is subcontracted? __________________________
Are certificates of insurance obtained for outside contractors? **Yes No**
Any work performed above two stories? **Yes No** If yes, describe: _______________________________________
Any excavation work performed? **Yes No** If yes, maximum depth: _______________________________________
Any work performed on barges, vessels, docks, or bridges over water? **Yes No**
Is job training provided? **Yes No** Forklift/machinery training? **Yes No**
Any out of state travel? **Yes No** If yes, how often, duration and why? _________________________________
Is employee transportation to and from the jobsite provided? **Yes No**
If yes, are the employees permitted to ride in vehicles other than cabs? Describe reason: _____________________
Any changes in Operations in the last 5 years: ____
% of off premises operations: _______% If yes, where/what? ____
Do you own, operate, or lease aircraft/watercraft? **Yes No**

VEHICLES:

Any vehicles owned by the company? **Yes No**
If yes, number and type of vehicles owned: **Autos:** ______ **Vans:** _____ **Trucks:** _____ **Tractors:** ________
Vehicle maintenance program: **Yes No**
Are vehicles taken home? **Yes No** If yes, number taken home: _____ What is the employee's position? ________
Do employees use personal vehicles during business hours? **Yes No**
If deliveries are made with company owned vehicles, what is the frequency: **Daily Weekly Other:**__________
Delivery radius: U**nder 50 miles 50-100 miles 100-200 miles Over 200 miles**
Is there a formal MVR check in place (i.e.: DMV's "MVR Pull Program"): **Yes No**
Include a drivers list – Name_____________Date of Birth_______________ Drivers License number________

CONSTRUCTION TRADES: N/A

Percentage of new construction: Residential ________ %Commercial_______% Industrial ________%
Percentage of remodeling: Residential ________ %Commercial _______% Industrial ________%
Percentage of repair work: Residential _________% Commercial _______% Industrial _______%

PREMISES:

Housekeeping/Cleanliness at the premises/jobsite: **Excellent Good Poor**
Are aisle ways clear and premises always free of congestion and in good repair? **Yes No**
Condition of equipment: **Excellent Good Poor**
Number of years at current location? _________ Age of building occupied? ______________
Any jobsite security provided: **Yes No** If yes, what type?
Dogs Armed Guards Unarmed Guards Other: _______________________
Are there video surveillance cameras? **Yes No**
Building Construction: Frame Block Metal CTU Building stories: _________
Year Building built: __________ Total Square Footage ___________
Alarmed: Central Local N/A Building Sprinkled: Yes No

HIRING PRACTICES:

Complete written applications: **Yes No**
Reference checks: **Yes No**
Pre/post employment physicals? **Yes No**
Drug/substance abuse tests; **Yes No**
Pathogenic test (i.e. lead): **Yes No**
Audio testing: **Yes No**
Orthopedic back test: **Yes No**
MVR's checked: **Yes No**
If drug tests are performed, are they: **Pre-Placement Post-Placement Random**
Are personnel records documented for pre-existing injuries? **Yes No**
How are potential new employees hired? (check all that apply)
Referrals Word of Mouth Newspaper Ads

EMPLOYEES:

Number of employees: Full time: ______ Part time: ______ Seasonal: ______ Rehires: ______
If seasonal, for what period of time are they hired and what are their duties? ________________________
Number of employees under age 16 __________ over age 70 ____________
Percent of leased or temporary employees: ________**%**
Any volunteer or donated labor? **Yes No** If yes, do you keep track of volunteer hours? **Yes No**
Number of W2s filed last year: ________ Number of 1099s issued last year: _______
Do you use union employees? **Yes No** If yes, name of union:_________________ percent_________%
Employee turnover is: **Low Average High**
Percent of same employees on payroll for the last: 12 months: ______**%** 24 months: ______**%**
What is the average hourly wage? **$**______ per hour
Any interchange of labor with another business or subsidiary? **Yes No**
Do any employees telecommute or work from home? **Yes No**

SAFETY:

Person responsible for safety/risk manager: _________________ Phone #: _____________________

Full time safety director: **Yes No** Part time (Less than 50%) **Yes No**

Does insured use a specific medical provider to treat injured employees? **Yes No**

Set procedures for reporting claims? **Yes No** Is there a formal accident report? **Yes No**

Is there an accident investigation program in place? **Yes No**

If yes, are the underlying root causes determined and corrective action taken? **Yes No**

Is there an active injury & illness prevention program? **Yes No** Written safety program (SB 198): **Yes No**

Are written premises and jobsite safety self-inspection checklist provided? **Yes No**

If yes, how often? **Daily Weekly Monthly Other:** ________________________________

Is a current OSHA 300 Log maintained? **Yes No**

Safety incentive program? **Yes No** If yes, what type?:____

Safety training program in place for new employees: **Yes No**

Is safety training conducted for all employees? **Yes No** If yes, is it documented? **Yes No**

How often are they conducted? **Weekly Bi-Monthly Monthly Quarterly Annually**

Describe the specific training provided: ____

Has a loss control or safety inspection been performed on you premises in the last year? **Yes No**

Safety/tailgate meetings conducted for all employee: **Yes No** How often:_______________

Machine Guarding: Point of operation – **Yes No** Drive Mechanism – **Yes No** Moving parts guarded – **Yes No**

Lock out/ tag out program in place: **Yes No** Equipment inspection program: **Yes No** If yes, describe:

____

Types of machines and %: Heavy _________**%** Mid ___________**%** Light____________%

Age of machinery: **Under 2 Years 2 to 5 Years 5 to 10 Years Over 10 Years**

Material Handling: Forklifts **Yes No** Cranes **Yes No** Hand trucks **Yes No**

Maximum Manual Lifting? **0-25 lbs 25-50 lbs 50-100 lbs 100+ lbs**

How is the lifting exposure controlled? **Manually Automated**

Any material handling training? **Yes No** If yes, describe: _____________________________________

Is personal protective equipment provided? **Yes No** If yes, is use enforced? **Yes No**

Type of protective equipment used: ____

Hazardous materials communication program in place: **Yes No**

Any storing, treating, discharging, applying, disposing, or transporting of hazardous materials? **Yes No**

If yes, describe: ____

Industrial truck/vehicle program in place: **Yes No** Violence intervention program: **Yes No**

Drug/alcohol awareness program: **Yes No** First aid kit kept at the jobsite: **Yes No**

Is first aid training conducted? **Yes No** Any employees trained in first aid? **Yes No**

Any employees trained in CPR: **Yes No** Slip & fall prevention program in place: **Yes No**

PAYROLL & EXPIRING PREMIUM INFORMATION:

Provide total payroll for the current expiring and past four policy years and expiring premiums on past policies.

	Payroll	Premium
Expiring 2009	______________________	**Estimated**______________________
2008	______________________	______________________
2007	______________________	______________________
2006	______________________	______________________
2005	______________________	______________________

Ownership: ___________________________ **Title**________________ **Percentage** ________ **Incl/Excl**

Ownership: ___________________________ **Title**________________ **Percentage** ________ **Incl/Excl**

Ownership: ___________________________ **Title**________________ **Percentage** ________ **Incl/Excl**

Signature of Applicant: ____ **Date:** __________________

Mh/6/03