

WORKERS COMPENSATION QUESTIONNAIRE

Named Insured: _____

Schedule & Description of locations: (office / yard / shop, etc):

Description of Operations: _____

Years in Business: _____

Any change in operations last 5 years? _____

List all combinable entities:

NAME	YRS IN BUS	Desc of operations	% of ownership

Workforce

Class code	# of EE	Avg Wage	Turnover %	Desc of tasks performed (i.e. – Supervision, rig hand)

Are there written job descriptions? Yes No

Average employee tenure: _____

Number of employees under 25: _____ Number of employees over 50: _____

Do your employees work on or near a navigable waterway? Yes No

Do any employees work from vessels? Yes No

Do you own or lease any aircraft? Yes No

Do any of your employees act as pilot? Yes No

Comments

- Written pre-employment applications used? Yes No _____
- Are references checked? Yes No _____
- Are pre-employment physicals required? Yes No _____
- Is there a Return to Work program in place? Yes No _____
- Do you offer paid sick leave? Yes No _____
- Are paid vacations available? Yes No _____
- Is there pre-employment drug-screening? Yes No _____
- Are employees unionized? Yes No _____
- Do you use leased employees? Yes No _____
- Do you have part-time employees? Yes No _____
- Are employee health plans available? Yes No _____
- Are employee retirement plans available? Yes No _____

Safety Programs:

Do you have a formal **safety program**? Yes No please describe

Is there a **loss control incentive** program? Yes No please describe

Who is accountable for enforcement of safety program: _____

Is **formal training** provided for:

New employees Yes No
For new Job assignments? Yes No

Please describe training programs:

Is there an **orientation program** for new employees? Yes No please describe

How often are safety meetings held? _____

Is attendance mandatory? Yes No

Is there a safety committee? Yes No

Describe type of personnel protective equipment used:

Type of equipment	Mandatory	Optional
Hard hat		
Steel Toe Boots		
Harnesses		
Safety Eye / Ear		

Is personnel protective equipment provided by the employee or the company? _____

Any changes to improve safety over the last 5 yrs: _____

Who is responsible for reporting accidents/claims: _____

Is post accident drug testing conducted? Yes No

Do you have an accident investigation program in place: Yes No _____

Are statements obtained from witnesses when an accident occurs? Yes No

Do you keep accurate personnel files on each employee? Yes No

Will you commit to a written return to work program? Yes No

Are there any know occupational disease exposures? Yes No

Maritime Employers Liability exposures?	Yes	No
Airplane flight crews?	Yes	No
Any work outside the United States?	Yes	No

Does your company have a website: _____

Any work related accidents not reported to the insurance company last 3 years?

All information will be verified through a physical loss control survey.
Please make sure all items have been completed.

I have read the above application. I declare that to the best of my knowledge and belief the statements and information in this application and any attachments thereto are true, accurate and complete. This information is given to the insurer for the specific purpose of obtaining insurance coverage. It is agreed that if any information given in this application or in any attachments thereto is materially false, inaccurate or incomplete, the insurer may deny coverage or cancel the policy.

Signature:

Insured

Title

Producer

Date