

Named Insured: _____ **Effective Date:** _____

Website: _____

General Information

1. Does the insured provide any medical benefits to their employees? Yes No
 Percentage of employees participating in the Group Health Plan: _____%
 Who is eligible? Full-time employees Part-time employees Seasonal Mgr/Supv Only
2. Employee turnover in the past year? _____% What was the turnover the year prior? _____
3. Are there any employees under 18 or over 65? Yes No. If yes, what percentage? _____%
4. Are there any Leased Employees? Yes No
5. How long has insured been in business? _____ If less than 3 years, what previous experience do the owners or managers have in this industry? _____
6. Is this a multi-location account? Yes No If yes, please complete the Multiple Location Section on page 4
7. Any employees trained in First Aid/CPR? Yes No Is there an on-site medical facility? Yes No

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/Post Physicals Required | <input type="checkbox"/> Yes <input type="checkbox"/> No | Written Job Descriptions | <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 |
| 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 | _____ |

Safety Program

- | | | | |
|---|--|---------------------------------------|--|
| Is there a full time Safety Director? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, name: | _____ |
| Formal 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 |
| Formal Return-to-work Program | <input type="checkbox"/> Yes <input type="checkbox"/> No | Modified/Light Duties | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergency Evacuation Plan | <input type="checkbox"/> Yes <input type="checkbox"/> No | Evacuation Drills on Regular Basis | <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 | Hazard Communication Program | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Documented Physical Inspection of premises? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Maximum weight lifted manually | _____lbs | List mechanical lifting devices used: | _____ |
| Are there any employees working from heights? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

If yes, describe duties: _____

Is there an equipment maintenance program in place? Yes No

- | | | | |
|---|--|---|---|
| Personal protection equipment provided? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mandatory? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Back Belts | <input type="checkbox"/> Goggles | <input type="checkbox"/> Masks | <input type="checkbox"/> Face Guard <input type="checkbox"/> Gloves |
| <input type="checkbox"/> Hearing Protection Devices | <input type="checkbox"/> Respirators | <input type="checkbox"/> Non-Slip Shoes | |

Insured Operations

1. Union operation? Yes No
2. Hours of operation: _____ AM TO _____ AM How many shifts? _____
3. How many working hours per shift? _____
4. 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: _____

 Operations include any transportation of guests? Yes No
 # of Vehicles: _____ # of Drivers: _____
 If yes to above, explain briefly where guests are transported: _____
5. Is there transportation of employees to and from work or employees being shuttled by the employer to an off-site parking lot? Yes No
6. Is there a vehicle inspection/maintenance program? Yes No
7. Has a driver acceptability standard been established? Yes No
8. Are MVRs checked on a regular basis? Yes No If yes, how often? _____
9. How many rooms is a housekeeper required to clean per day? _____
10. Are there any off-premise operations? Yes No If yes, advise: _____ % Explain duties: _____
11. If an employee enters a guest room, is he/she accompanied by security or other employee nearby? Yes No
12. Any interchange of employees? Yes No If yes, explain: _____
13. Are employees permitted to use personal vehicles for errands/deliveries? Yes No
14. Any out-of state or country traveling? Yes No
 Describe _____
 Does the insured have a Foreign Coverage Policy? Yes No
15. Does the insured subcontract out any portion of their normal operations? Yes No If so, please describe what operations are subcontracted. _____
16. If subcontractors are used, are proper certificates of insurance obtained? Yes No

Employee Count:

1. What is the current total number of employees? _____ (Note: if multiple locations, please include schedule of employees count per each location with submission). What was prior year number of employees _____
2. What is the maximum number of employees on site at any one time? _____
3. Is the number of employees: Increasing Decreasing Stable
4. What is the average length of employment? _____ Average number of years' experience? _____
5. Any future layoffs foreseen?: Yes No

Management:

1. Owners: Active in Management: Yes No
 Absentee: Yes No
2. Are formal claims reporting procedures in place? Yes No
3. Is there an employee dedicated to claims oversight? Yes No

Premises:

1. Describe briefly the condition of the premises: _____
2. Are hazards identified and adequately controlled? Yes No
3. Are upgrades to systems and premises done on regular basis? Yes No

Restaurant Operations (if any):

1. Are there any offsite catering operations? Yes No If yes, what % of receipts are from catering? _____
2. Any banquet facilities? Yes No
3. Are cooking facilities adequately protected by extinguishing equipment? Yes No
4. How often are facilities inspected and services? (e.g. annually, monthly, weekly, etc.) _____
5. Are slip resistant shoes required? Yes No
6. Do all walk in freezers have safety latches on the inside? Yes No

Premium/Payrolls: Provide final audited premium/payroll

		<u>PREMIUM</u>	<u>PAYROLL</u>	<u>EXPERIENCE MODS</u>
Expiring Year	Est	\$ _____	\$ _____	_____
1st Prior		\$ _____	\$ _____	_____
2nd Prior		\$ _____	\$ _____	_____
3rd Prior		\$ _____	\$ _____	_____
4th Prior		\$ _____	\$ _____	_____

Multiple Location Accounts Only:

1. How many locations does the insured operate/manage/own? _____
2. Is there a risk manager in place at the corporate level? Yes No
3. Does corporate monitor the claim activity at all locations? Yes No
4. Does corporate provide each location with a formalized safety program? Yes No
5. Are the locations held to minimum standards with regard to safety and risk management protocols?
 Yes No
6. Does corporate perform regular assessments of the locations? Yes No
7. Does corporate hold regular company-wide or regional meetings with location management? Yes No
If yes, how often? _____
8. Does corporate hold location management responsible for loss experience at their site? Yes No
9. Does corporate monitor the results of loss control surveys at the sites? Yes No
10. Does corporate hold location management responsible for responding to loss control recommendations?
 Yes No