



HEFFERNAN INSURANCE BROKERS

A Member of the Heffernan Group

Workers' Compensation Questionnaire

Your Name: _____ Owner's Name: _____

Name of Company: _____

Address: _____ City, State Zip : _____

Phone Number: _____ Fax Number: _____

Email: _____ Website: _____

Date Company Established/#years in Business _____

Federal Employer I.D. #: _____

Owners, Officers, Directors or Partners, Included or Excluded:

Names & Titles: _____

Excluded or Included: _____ % of Ownership: _____

Do you provide Health insurance to your full time employees? _____
 If yes, do you pay for 50% or more _____ Who is the provider _____

- Attach a copy of the Declaration & Payroll pages from your current policy **OR** provide the following information:

CLASSIFICATION	CLASS CODE	# of Emp. Pier Diem	# of Emp. Full Time	ESTIMATED ANNUAL PAYROLL
Public Health Nursing	8827 or 8835			\$
Homemaking Services	8827 or 8835			\$
Clerical	8810			\$
Hospitals/Nursing Homes	9043			\$

- **Please provide the most current Workers' Compensation claims for the past five years.**
- Please fax back to Tami Unsworth at 925-934-8278 or call with questions at 925-942-4619.



WorkComp**GUARD**SM

Supplemental WC Questionnaire

Instructions:

- Please type or print clearly in ink. All sections must be completed fully.
- If you need more space, attach additional sheets as needed, using company letterhead

Firm Name: _____
 (If more than one entity/subsidiary, please attach description and % owned for each)

- 1) How long has the applicant been in business under this name? _____ If less than 3 years, provide a copy of the resume of the owner/manager of this entity.
- 2) Is the applicant currently in the assigned risk pool? Yes No
- 3) Does the applicant own, operate or lease any watercraft or aircraft? Yes No
- 4) Does the applicant use volunteers or donated labor? Yes No
 If "yes", what is the percentage of donated labor as compared to paid labor? _____
- 5) Does the applicant provide employee health plans? Yes No (If yes, indicate type of plan, outline participation, & eligibility): _____
- 6) Is the applicant a PEO, Employee Leasing Company, Temporary Staffing Agency, Labor Contractor or otherwise supply employees to another employer on a contract, temporary or on call basis? Yes No
 If "yes", please explain: _____
- 7) Does the applicant have exposures (excluding outside sales and/or clerical payroll) in more than 7 states? Yes No
- 8) Has the applicant incurred any single loss greater than \$25,000 over the last 3 years? Yes No
- 9) Has the applicant's WC coverage been cancelled in the past year for underwriting reasons? (N/A in MO) Yes No
 If "yes", please explain: _____
- 10) Has the applicant's WC coverage been cancelled for nonpayment within the last 3 years? (N/A in MO) Yes No
- 11) Is there workers compensation coverage currently in force? Yes No
- 12a) Number of employees traveling outside of the U.S. per year: _____ 12b) Number of days worked per employee outside of the U.S. per year: _____ 12c) Choose Repatriation Limit: \$5,000 \$10,000 \$15,000 \$20,000 \$25,000
- 13) Are certificates of Workers' Compensation insurance maintained for all work performed by sublet labor? Yes No
- 14) Has the insured provided certification for the implementation of an acceptable Drug Free Workplace Program? Yes No
 If "yes" is the insured involved in pre-employment/random drug testing? Yes No
- 15) Does the insured have a Workplace Safety Program in place? Yes No
- 16) Please indicate which of the following safety program elements are currently in effect:

<input type="checkbox"/> Driver Safety Program	<input type="checkbox"/> Accident/Injury Investigations	<input type="checkbox"/> Labor/Management Safety Committee
<input type="checkbox"/> Safety Incentive Program	<input type="checkbox"/> Patient Handling/Transfer Training	<input type="checkbox"/> Mentoring process for new employees
<input type="checkbox"/> New Employee Orientation	<input type="checkbox"/> Personnel Evaluations include "safety"	<input type="checkbox"/> Driver Training/Travel Logs
<input type="checkbox"/> Return to Work/Modified Duty	<input type="checkbox"/> Screening process for new hires	<input type="checkbox"/> Functional testing of new hires
<input type="checkbox"/> Management Involvement in safety (describe if checked)		<input type="checkbox"/> Complies with Loss Control promptly

 Describe: _____
- 17) Has the insured provided certification of attendance to a state-sponsored cost containment seminar? Yes No

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Supplemental WC Questionnaire

18) Does the insured operate a licensed nursing home or provide medical & personnel care to the aged or infirm? Yes No
If "yes", please describe: _____

19) Explain the care and condition of the insured's premises to include the following:
Housekeeping: _____
Debris Removal: _____
Age & Condition of equipment: _____
Equipment safety guarded: _____

20) Indicate employee annual turnover rate _____ %

21) Does the applicant have general liability and professional liability insurance in force? (If yes, state carrier) Yes No

22) Business Operations (check all that apply):

<input type="checkbox"/> Home Health Care Provider	<input type="checkbox"/> Visiting Nurse Agency	<input type="checkbox"/> Supplemental Medical Staffing
<input type="checkbox"/> Hospice Provider	<input type="checkbox"/> Nurse Registry	<input type="checkbox"/> Medical Equipment Supplier
<input type="checkbox"/> Retail Pharmacy	<input type="checkbox"/> Closed Pharmacy	<input type="checkbox"/> Infusion Therapy Provider
<input type="checkbox"/> Rest Home	<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Physical Therapy / Occ. Health
<input type="checkbox"/> Mental Health Counseling	<input type="checkbox"/> Crisis Response Team	<input type="checkbox"/> Substance Abuse Counseling
<input type="checkbox"/> Drug Treatment/Detox	<input type="checkbox"/> Inpatient Psychiatric Treatment	<input type="checkbox"/> Crisis Hotline
<input type="checkbox"/> Halfway House	<input type="checkbox"/> Onsite Pharmacy	<input type="checkbox"/> Crisis "shelters"
<input type="checkbox"/> Job Assistance	<input type="checkbox"/> Outpatient Psychiatric Clinic	<input type="checkbox"/> Community Hospital
<input type="checkbox"/> Clinic	<input type="checkbox"/> Other (please specify): _____	

23) Please indicate where your employees perform their work:

<input type="checkbox"/> Private Homes/Apt. _____ %	<input type="checkbox"/> Clinics _____ %	<input type="checkbox"/> Nursing Homes _____ %
<input type="checkbox"/> Doctor's Offices _____ %	<input type="checkbox"/> Hospitals _____ %	<input type="checkbox"/> Corporate Offices _____ %
<input type="checkbox"/> Clinic Setting _____ %	<input type="checkbox"/> Community Residences _____ %	<input type="checkbox"/> Other Locations _____ %

(Please describe below)

Please describe: _____

24) Please enclose any available informational brochures describing operations, locations, services, etc.

25) Website Address: www. _____

Applicant Name (printed): _____ Signature: _____

Broker/Agent Name (printed): _____ Signature: _____

Supp 10/26/09

Smith, Bell & Thompson Inc.
 Gateway Square, 40 Main St., Suite 500, P.O. Box 730, Burlington, Vermont 05402-0730
 Telephone: (802) 658-4600 or toll-free (800) 735-1800
 Fax: (802) 658-6191 or (802) 862-2180 www.sbtinsurance.com

Named Insured: _____		Web Address: _____	
Insured's FEIN: _____			
Contact Name and Phone Number			
Inspections:	_____	()	-
Premium Audit:	_____	()	-
Claims:	_____	()	-
Prior Payroll and Premium Information			
	<u>Total Annual Payroll</u>		<u>Premium \$</u>
2010	_____	_____	_____
2009	_____	_____	_____
2008	_____	_____	_____
2007	_____	_____	_____
2006	_____	_____	_____
Operations and Benefits			
Please provide a detailed description of the operation: _____			

Years in business? _____	Hours of operation- _____ to _____	# of Shifts - _____	
Is there a driving/delivery exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Radius of operations/travel: <input type="checkbox"/> <50 miles <input type="checkbox"/> 50-100 <input type="checkbox"/> 100+		
If yes, what is frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other: _____	Any group transportation of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is a PUC/DMV filing required? <input type="checkbox"/> PUC <input type="checkbox"/> DMV <input type="checkbox"/> N/A			
Are vehicles company owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how provided? <input type="checkbox"/> car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus		
If yes, are vehicles taken home? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of employees transported per vehicle _____		
# Of vehicles? _____ # Of drivers? _____	# of vehicles used to transport _____		
Vehicle/fleet maintenance program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		
If yes, who does the servicing? <input type="checkbox"/> Outside vendor <input type="checkbox"/> In-house mechanics <input type="checkbox"/> Other: _____			
Do employees use personal vehicles for company business? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do any employees work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Any out of state, international or overnight (within state) travel? <input type="checkbox"/> Yes <input type="checkbox"/> No	List the # of employees who live or work out of state:		
If yes, please provide details - _____	_____ Live		_____ Work
Why/purpose? _____			
Who will travel? _____	Where? _____		
Duration? _____	Frequency? _____		
(Verify number is consistent with the number on ACORD Application)			
# of employees: Full time _____ Part-time _____ Seasonal _____ Volunteers _____			
# of W-2's issued - Last year _____ Previous year _____	How are employees paid? <input type="checkbox"/> Hourly		
Any day laborers or temporary/employee leasing? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Piece rate <input type="checkbox"/> Commission <input type="checkbox"/> Flat salary		
If yes, please provide details on separate page.	<input type="checkbox"/> Other: _____		
% of union employees _____ % of non-union _____	Paid Sick Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Actual average hourly wage for employees in governing class \$ _____/hour	Paid Vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Retirement / Pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Does employer contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Group medical provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	% of employees enrolled _____		
If yes, name of healthcare provider - _____	% paid by employer _____		
Do you use a specific medical provider to treat injured employees? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you currently participating in a MPN (Medical Provider Network)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide the name of current MPN: _____			
CPR training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	RTW Program? <input type="checkbox"/> Yes <input type="checkbox"/> No		
# of employees certified? _____	Does it include salary continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the ownership of the applicable entity changed within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details on attached sheet.			

Hiring Practices -- Employee Selection - Claims

Written Application? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-hire drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reference Checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Post Accident drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre/post employment Physicals? <input type="checkbox"/> Yes <input type="checkbox"/> No	MVR Checks? <input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic back testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Audio hearing tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
Formal job descriptions on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a formal written accident report? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are personnel files documented for pre-existing injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there set procedures for reporting claims? <input type="checkbox"/> Yes <input type="checkbox"/> No
Average claim reporting time frame - _____	Any Interchange of labor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is job specific training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain <input type="checkbox"/> Another business <input type="checkbox"/> Subsidiary
Employee Orientation Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> between departments <input type="checkbox"/> Other: _____
If yes, is the orientation <input type="checkbox"/> Verbal only? <input type="checkbox"/> Verbal and Documented?	
Supervisor to Employee ratio - <input type="checkbox"/> Better than 4-1 <input type="checkbox"/> 5-1 <input type="checkbox"/> 6-1 <input type="checkbox"/> 7-1 <input type="checkbox"/> >7-1	
Subcontractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____	
If yes, are certificates of insurance obtained and kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Independent contractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____	
If yes, how are they paid? <input type="checkbox"/> 1099's? <input type="checkbox"/> Other? Please explain- _____	

Safety Program and Organization -- Work premises and Environment

Are owners active in daily operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are they excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Active injury & illness prevention program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has loss control services been performed in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Active safety incentive program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Cal/OSHA visited or cited your business in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does it encompass all employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide explanation on separate page.
What type of incentive? _____	Are safety meetings conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do employees receive safety training/orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly
If yes, is the training - <input type="checkbox"/> Formal / Documented <input type="checkbox"/> Informal	<input type="checkbox"/> Other: _____
Do you have a safety director or risk manager? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and title: _____
If yes, is the position full time or an additional responsibility of another employee? _____	
MSDS (Material Safety Data Sheets) available for all chemicals and products used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Any material handling exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____	
Any lifting exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Forklift training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, <input type="checkbox"/> <25 lbs. <input type="checkbox"/> 25-40 <input type="checkbox"/> 40+	If yes, annual certification? <input type="checkbox"/> Yes <input type="checkbox"/> No
If 40+, manual lifting or with assistance? Please explain _____	
Is all machinery/equipment properly guarded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Any use of Baler equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Written Lock out / tag out / block out procedures in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Condition of equipment? <input type="checkbox"/> New <input type="checkbox"/> Good <input type="checkbox"/> Average
Respiratory program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Are all equipment operators trained/ certified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
What is the maximum height at which you will work? _____	Personal protection equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
What is used? <input type="checkbox"/> Ladder <input type="checkbox"/> Scaffolding <input type="checkbox"/> Scissor lifts <input type="checkbox"/> N/A	If yes, strict enforcement of utilization? <input type="checkbox"/> Yes <input type="checkbox"/> No
If scaffolding used, does the insured build their own? <input type="checkbox"/> Yes <input type="checkbox"/> No	What types of PPE? _____
Is the building / premises - <input type="checkbox"/> Owned or <input type="checkbox"/> Leased?	# Of years at current location? _____
Condition of premises? <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Average	Age of building occupied? _____ year(s)

Manufacturing – Machine Shops

Any punch press or press brake machinery/equipment? Yes No Machine Guarded: Point of operation Drive Mechanism
 Accessible moving parts guarded on machinery/equipment? Yes No
 Age of machinery: <2 yrs 2-5 yrs 5-10 yrs 10+ yrs
 Types of machines (must equal 100%) - Heavy ___ Mid ___ Light ___ Any Computer Network Controlled (CNC) machinery? Yes No
 % of off-premise operations: ___ If yes, where/what for? _____
 Is building properly ventilated? Yes No Is proper dust collection system in place? Yes No

Retail / Wholesale

Type of Merchandise? _____
 Gross Receipts: Wholesale ___ % Retail ___ % Warehousing? Yes No
 Any repacking or repackaging operations? Yes No
 If yes, please explain operations: _____
 Assembly exposure? Yes No
 If yes, please explain exposure: _____
 Any distribution exposure? Yes No If yes, by common carrier or does insured have a trucking exposure? Please explain on separate page.

Trucking

Type of Authority: a) Common Carrier Contract Carrier Private Brokerage Exempt
 b) Regular Route Irregular Route
 Carrier Operations: California Only Interstate
 Length of Haul with Total % = 100%:

Under 50 Miles ___ %	50 – 200 ___ %	201 – 300 ___ %
301 – 500 ___ %	501 – 1,000 ___ %	Over 1,000 ___ %

Filings: DOT# _____ PUC# _____ DMV/MCP# _____ Not Applicable

Please Check the Questions and Attached the Applicable Data:

Motor Carrier Identification Report, MCS-150: Attached or Not Applicable
 Cargo Classification: See attached MCS-150 or See below (check all that apply):
 General Freight Logs, Poles Beams, Lumber Liquids/Gases Grain, Feed, Hay Chemicals
 Household Goods Building Materials Intermodal Containers Coal, Coke Commodities Dry
 Bullion
 Metal Sheets, Coils, Rolls Mobile Homes Passengers Meat Refrigerated Food
 Motor Vehicles Machinery, Large Objects Oilfield Equipment Garbage, Refuse, Trash Beverages
 Driveway/Towaway Fresh Produce Livestock U.S. Mail Paper Products
 Other _____

Drivers: a) Number of Drivers _____ b) Number of Owner/Operators used _____
 - Percentage where the Motor Carrier will provide workers' compensation for the Owner/Operators ___ %
 - Percentage where the Motor Carrier will agree with the Owner/Operator that the Owner/Operator assumes the responsibilities of an Employer for the performance of work: ___ %
 c) If Owner/Operators used, please attach copy of contract: Attached or Not Applicable
 d) Number of company drivers with Motor Carrier at least 12 months: _____
 Number of Owner/Operator with Motor Carrier at least 12 months: _____ or Not Applicable
 e) Number of Non-Union: _____ Union: _____
 f) Do the drivers load and unload their trucks? No Yes (please provide detail of the types of materials loaded/unloaded and any equipment used: _____
 Is the applicant enrolled in the DMV Pull Program? Yes No If so, how often? _____
 Is the applicant enrolled in the CHP BIT Program? Yes No

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Care West Insurance Risk Management, LLC must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Signature of Applicant: _____ Date: _____