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**WORKERS
 COMPENSATION
 QUESTIONNAIRE**

GENERAL INFORMATION AND OPERATIONS

Company Name: _____
 Operations _____
 Applicant FEIN: _____
 Applicant WCIRB#: _____
 Contractor's Lic#: _____
 Contact Name: _____
 Title _____ Tel # _____ Fax # _____

Number of years in business: _____ If less than 5 years, number of years in trade: _____
 Number of locations: _____ Foreign Travel: Yes No
 Out of State Exposure: Yes No If yes, name of states: _____
 Hours of operation: from _____ to _____ Number of days per week: _____ Number of daily shifts: _____
 Out of state exposure: Yes _____ No _____ If yes, name of states: _____ Number of employees: _____
 Is the owner active in the business: Duties performed: _____
 Describe operations of the Applicant: _____

EMPLOYEE INFORMATION

Present number of employees: Full time: _____ Part time: _____ Seasonal: _____ Volunteers: _____
 Percent of employee turnover in the last 12 months: Full time _____ Part time _____
 Employee turnover is: Low Average High
 Employee staffing expectations over the next 12 months: Full time: _____ Part time: _____
 Number of employees are: Increasing: Stable: Decreasing:
 Average Hourly wage: Full time \$ _____ Part time: \$ _____
 What is the hourly wage of the governing class of employees: \$ _____ per hour.
 Piecework based compensation: Yes No
 Number of Employees telecommuting: _____ What percentage does employee work per week _____%

PAYROLL / PREMIUM / LOSS INFORMATION

Year	Payroll	Premium	Total Incurred Losses*	# Claims	Loss Ratio
Current	\$	\$	\$		
1 st Prior	\$	\$	\$		
2 nd Prior	\$	\$	\$		
3 rd Prior	\$	\$	\$		
4 th Prior	\$	\$	\$		
	Totals	\$0	\$0	0	

*Provide details of any single claim or loss over \$25,000 on Claim Supplement

EXPOSURE INFORMATION Total number of **all** employees: _____

TOTAL NUMBER OF FIXED LOCATION EMPLOYEES									
State	Location #	Payroll	Total # of Employees	# of shifts	Maximum # of Employees per shift	Type of Building (see list below)	Year Built	# of Stories	Floors occupied
		\$							
		\$							
		\$							
		\$							
		\$							
		\$							

If additional locations exist please include on a separate form. Type of Building: (1) Steel 3 stories or greater, (2.) Frame 3 stories or less, (3.) Concrete tilt up

MANAGEMENT

Does Applicant have a return to modified duty program: Yes No If yes, with full pay: Yes No
Is the Applicant willing to implement loss control recommendations made by the carrier: Yes No
Supervisors are held accountable for injuries / accidents: Yes No
Accident investigation program in place: Yes No

Additional Comments: _____

BENEFITS

Does Applicant provide benefits to all employees eligible? Yes No
Employer contribution Yes No What % of employees are covered by the Plan _____%
Group Health: Yes No
Paid sick leave: Yes No
Vacation Yes No
Retirement./ Pension plan: Yes No
Waiting period: 30 days 60 days 90 days Other: _____
Name of group medical provider: _____
Who is eligible? All employees Only full time Other: _____
Does Applicant provide life insurance? Yes No If yes, employer contribution _____%
Does Applicant provide Disability Insurance? Yes No If yes, contribution: _____%
Paid vacation: Yes No Paid sick leave: Yes No 401K Profit Sharing: Yes No
Full time nurse maintained on staff: Yes No CPR training provided: Yes No
Would you participate in an HCO program to control claim costs? Yes No

HIRING PRACTICES

Complete written applications: Yes No
References checked: Yes No
Pre/Post employment physicals: Yes No
Orthopedic back test: Yes No
Drug/Substance abuse tests: Yes No
MVR's checked: Yes No
Written Test: Yes No
Volunteer labor used: Yes No
Temporary Labor used: Yes No
If yes: Name of Temp agency and name of WC carrier: _____
Audiometric Testing: Yes No
Pathogenic Testing: Yes No
Turnover rate: _____%
How are potential new employees hired? (check all that apply):
Referrals Word of mouth News Paper Ads
Recruiters Union Hall Other Describe: _____

SAFETY

Person responsible for safety: _____ Phone: _____
Does Applicant use a specific medical provider to treat injured employees: Yes No
Clinic Physician Emergency Room Other: _____
Provide Name of clinic, physician or Emergency room used for work place related injury: _____
Written safety program (SB 198): Yes No
Safety incentive program: Yes No
Full time safety director: Yes No Name: _____
Part time (less 50%): Yes No
Safety / Tailgate meetings conducted for all employees: Yes No Frequency of meetings: _____
Safety training program in place for employees: Yes No
Equipment safeguards utilized: Yes No
Personal protective safety equipment provided for all employees: Yes No
Equipment inspection / Maintenance program: Yes No
Slip and Fall Prevention Program in place: Yes No

SAFETY (Continued)

Hazardous Materials Communication program in place: Yes No
Lock Out / Tag Out program in place: Yes No
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 job site: Yes No

CATASTROPHE EXPOSURE

Does Applicant work within 2 miles of the following building or facilities:
Government or Military base: Yes No
Financial Institutions including national/regional stock exchange: Yes No
Sport Stadiums/Arenas and Theme Parks: Yes No
Major Bridges, Tunnels or Dams: Yes No
Utilities or Power Generation Plants: Yes No
Transportation Hubs, Railroads, Airports or Shipping: Yes No
Historic/Symbolic buildings, monuments or parks: Yes No

DELIVERY EXPOSURE

Delivery Exposure: Yes No Number of authorized drivers: _____ Number of vehicles: _____
Frequency of delivery: Daily Weekly Other _____
Delivery radius: Less than 50 miles 51-100 miles 101-250 miles More than 250 miles
Frequency of MVR checks: _____ Participation in CHP pull program Yes No
Driver acceptability has been established: Yes No
Vehicle inspection / maintenance program: Yes No
Vehicle maintenance is performed by employees: Yes No
Employees take vehicles home at night: Yes No

MEDICAL PROVIDER NETWORK COMPLIANCE – Applicable to Clarendon Only

If this application is new business to Clarendon:
Has the Insured previously participated in a Medical Provider Network? Yes No
Is the Insured willing to participate in Clarendon/TMC MPN? Yes No
If this application is renewal business to Clarendon:
Has the Insured implemented the Clarendon/TMC MPN? Yes No
If yes, when? _____
If not, will the Insured implement the Clarendon/TMC MPN during the next policy term? Yes No

Complete supplemental section(s) below if you have the following operations: Construction, Farms, Trucking, Hotel/Motel, retail, wholesale, manufacturing, Service stations/Auto repair shops/Transmission shops, Attorneys, Restaurants, Apartment owners/Building operations

BROKER INFORMATION

Does this broker currently control the workers' compensation? Yes No If yes, # of years: _____

Signature: _____ Date _____

TO BE COMPLETED FOR FARMS ONLY

Crops Grown	Avg. Acreage -	Harvested Mechanically	Type of Equipment
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	

- How many acres: 160 or less 161-499 500-999 1,000+
- Housing Provided: Yes No If so, how many employees: _____
- Transportation of employees: Yes No How: Van Bus Airplane Other:
Frequency: Daily Weekly Monthly Radius: _____
- Use Labor Contractor: Yes No
- Employees pay: Hourly rate _____ Piece rate _____ Combination _____ Other _____
- Operation outside of California: Yes No
- Dairy Barn: Elevated Carousel Flat Other _____
 - Number of Milking cows _____
 - Number of Bulls _____ Number of Bulls 3 years old & older: _____
 - Outside Veterinary Services: Yes No
 - Artificial Insemination: Yes No Subcontracted: Yes No
 - Hoof trimming: Yes No Subcontracted: Yes No
 - De-horn: Yes No Subcontracted: Yes No
- Does Applicant harvest crops for others: Yes No If so, own equipment used: Yes No

TO BE COMPLETED FOR CONTRACTORS ONLY

- Percentage of new construction: Residential _____% Commercial _____% Industrial _____%
- Percentage of remodeling: Residential _____% Commercial _____% Industrial _____%
- Percentage of repair work: Residential _____% Commercial _____% Industrial _____%
- Percentage of work subcontracted: _____
- Any work performed above 2 stories: Yes No yes, explain: _____
- Any use of Cranes: Yes No If yes, explain: _____
- Any use of Scaffolds: Yes No If yes, explain: _____
- Are deliveries made: Yes No Frequency: Daily Weekly Other: _____
- Delivery radius: Under 50 miles 50-100 miles Over 100 miles:
- Vehicles owned: Yes No If yes, take home: _____
- Vehicle maintenance program: Yes No
- MVR "Pull" program: Yes No
- Any changes in operations in the last 5 years: Yes No If yes, describe: _____
- Condition of equipment: Excellent Good Poor
- Any job site security provided: Yes No If yes, describe: _____

TO BE COMPLETED FOR TRUCKING EXPOSURES ONLY

- Commodities Hauled - Breakdown by % of Revenue: _____
- Any Hazardous or Oversized Cargo? Yes No
- Type of Equipment - Type of Number of Vehicles:

<input type="checkbox"/> Flatbed _____	<input type="checkbox"/> Tractor Trailer _____	<input type="checkbox"/> Double Trailer _____
<input type="checkbox"/> Tank _____	<input type="checkbox"/> Refrigerated _____	<input type="checkbox"/> Other _____
- Type of Carrier: Truckload(TL) Less than Truckload (LTL)
- Do drivers load and unload cargo? Yes No If yes, how often: _____% Palletized loads? Yes No
- How are drivers compensated: Per contract Hours logged Mileage Other _____
- Radius of operations: Local _____% Medium _____% Long Haul _____%
- Regular route? Yes No
- Out of state exposure? Yes No If yes, which states _____
- Are you in compliance with DOT? Yes No
- Any DOT/OSHA Citations in Last 4 Yrs? Yes No If yes, explain: _____
- Any warehouse exposure? Yes No If yes, explain: _____

TRUCKING (Continued)

- 13. Any Driver Monitoring Devices? Yes No
- 14. Are accidents reviewed for preventability? Yes No
- 15. Team Drivers? Yes No
- 16. Owner Operators? Yes No
- 17. Are Sub-Contractors hired? Yes No
- 18. Are Lumpers/Helpers hired? Yes No
- 19. Written maintenance program? Yes No
- 20. In house mechanics? Yes No
- 21. Vehicle maintenance records kept? Yes No
- 22. Pre-trip inspections? Yes No
- 23. Average age of Drivers: _____
- 24. Average age of vehicles: _____

TO BE COMPLETED FOR HOTEL / MOTEL EXPOSURES ONLY

- Number of guest rooms: _____ Room rate: Under \$50 \$50-\$74.99 \$75-\$99.99 Over \$100
- Food service: Operate own: Yes No Subcontract: Restaurant Bar Both
- Gross receipts: Food _____% Liquor _____%
- Entertainment: Yes No Lounge: Yes No Armed Security: Yes No
- Operation: Year found: Seasonal: Conference center: Yes No
- Shuttle service: Yes No How many vans? _____
- How are maids compensated: Salary Hourly wage Flat rate per room
- Who flips mattresses and how are they turned: _____

TO BE COMPLETED FOR RETAIL / WHOLESALE EXPOSURES ONLY

- Gross receipts: Wholesale _____% Retail _____%
- Compensation: Flat Salary Hourly wage Type of merchandise: _____
- Outside sales employees: Yes No Commission: _____
- Lifting exposure or repackaging: Yes No Lbs: _____ Is there assembly: Yes No
- If Yes, describe? _____

TO BE COMPLETED FOR MANUFACTURING EXPOSURES ONLY

- Machine guarding: Point of operation: Yes No Drive mechanism: Yes No Moving Parts: Yes No
- Lock-out/Tag-out program in place: Yes No
- Material handling exposure: Yes No Lifting: Below 50 lbs. Above 50 lbs.
- Off premises operations: Yes No Percentage: _____% Where/What: _____
- Type of machines used: _____

TO BE COMPLETED FOR SERVICE STATION / AUTO REPAIR / TRANSMISSION SHOP EXPOSURES ONLY

- Hours of operation: _____ Mini-Market: Yes No Liquor sold: Yes No
- Gas operation: Full service Self service Bullet proof cashier booth: Yes No
- Repair operation: Yes No Drop safe registers: Yes No
- Tire repair/installation: Yes No Over 1-ton trucks: Yes No
- Car Wash: Yes No If yes, self serve Full serve
- Towing: Yes No Contact tow: Yes No Access to freeway: 0-1 mile 1-2 Miles 2+ Miles

TO BE COMPLETED FOR ATTORNEY EXPOSURES ONLY

- What type of law: _____
- Any criminal law: Yes No
- Any insurance law: Yes No

TO BE COMPLETED FOR RESTAURANT EXPOSURES ONLY

- Average Entrée Price: _____ Take-out: Yes No % of revenues _____
- Liquor Receipts (% of gross receipts): _____ Catering: Yes No % of revenues _____
- Separate Lounge: Yes No Delivery: Yes No % of revenues _____
- Twenty-four hour operation: Yes No Valet Parking: Yes No
- Number of: Hosts: _____ Wait-staff: _____ Cooks: _____ Bartenders: _____ Radius of delivery area: _____
- Entertainment: Yes No If yes, please provide details: _____

TO BE COMPLETED FOR APARTMENT OWNERS / BUILDING OPERATIONS EXPOSURES ONLY

List of operations sub contracted to others: _____

Current employees perform maintenance operations for you: Yes No If yes please list: _____

The following items are maintained and kept current for all sub contractors:

Certificate of workers' comp insurance: Yes No

Copy of each sub contractor's license number: Yes No

List of sub-contractors and contractors license numbers: (if more than 3, use separate sheet)

1. _____
2. _____
3. _____

REINSURANCE INFORMATION : Must be completed for each location with 100+ employees

LOCATION 1.

Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Type of construction: Frame (code 1) Joisted Masonry (code 2) Non combustible (code 3)

Masonry Non combustible (Code 4) Modified fire resistive (Code 5) Fire resistive (Code 6)

Seismically retrofit: Yes No If yes, year completed: _____

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

Location is: Single building Multi Building Urban Suburban Rural

Class codes & payroll by code: _____

LOCATION 2.

Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Type of construction: Frame (code 1) Joisted Masonry (code 2) Non combustible (code 3)

Masonry Non combustible (Code 4) Modified fire resistive (Code 5) Fire resistive (Code 6)

Seismically retrofit: Yes No If yes, year completed: _____

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

Location is: Single building Multi Building Urban Suburban Rural

Class codes & payroll by code: _____

LOCATION 3.

Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Type of construction: Frame (code 1) Joisted Masonry (code 2) Non combustible (code 3)

Masonry Non combustible (Code 4) Modified fire resistive (Code 5) Fire resistive (Code 6)

Seismically retrofit: Yes No If yes, year completed: _____

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

Location is: Single building Multi Building Urban Suburban Rural

Class codes & payroll by code: _____

CLAIMS SUPPLEMENT (Losses over \$25,000)

Name of claimant:
Date of loss:
Description of Loss:
Claims Status: Open <input type="checkbox"/> Closed: <input type="checkbox"/>
Amount of claim: Total Incurred \$ Paid amount \$ Reserve \$
Is claimant back to work: Yes <input type="checkbox"/> No <input type="checkbox"/>
Action taken to prevent loss from occurring again: _____

Name of claimant:
Date of loss:
Description of Loss:
Claims Status: Open <input type="checkbox"/> Closed: <input type="checkbox"/>
Amount of claim: Total Incurred \$ Paid amount \$ Reserve \$
Is claimant back to work: Yes <input type="checkbox"/> No <input type="checkbox"/>
Action taken to prevent loss from occurring again: _____

Name of claimant:
Date of loss:
Description of Loss:
Claims Status: Open <input type="checkbox"/> Closed: <input type="checkbox"/>
Amount of claim: Total Incurred \$ Paid amount \$ Reserve \$
Is claimant back to work: Yes <input type="checkbox"/> No <input type="checkbox"/>
Action taken to prevent loss from occurring again: _____

Name of claimant:
Date of loss:
Description of Loss:
Claims Status: Open <input type="checkbox"/> Closed: <input type="checkbox"/>
Amount of claim: Total Incurred \$ Paid amount \$ Reserve \$
Is claimant back to work: Yes <input type="checkbox"/> No <input type="checkbox"/>
Action taken to prevent loss from occurring again: _____

Name of claimant:
Date of loss:
Description of Loss:
Claims Status: Open <input type="checkbox"/> Closed: <input type="checkbox"/>
Amount of claim: Total Incurred \$ Paid amount \$ Reserve \$
Is claimant back to work: Yes <input type="checkbox"/> No <input type="checkbox"/>
Action taken to prevent loss from occurring again: _____