

Landscaping - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date: / /	Legal Name:	Application ID:
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Application completed by: Broker: Employer:

Please provide (first, last) name: _____ Date: _____

<p>Please describe the type of landscaping services performed: (i.e. Sprinkler installation, Erosion Control Excavation or trenching work, etc.)</p> <div style="border: 1px solid black; height: 80px; margin-bottom: 10px;">[Text Here]</div> <p>Please list any equipment used (including tree trimming equipment):</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Percentage of operations: Residential ___% Commercial ___% =100%</p> <p>Percentage of operations: Mow/Blow ___% Landscape Design ___% =100%</p> <p>Do the operations include snow removal: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, do the operations include snow removal from rooftops? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do the operations include Tree Trimming: No <input type="checkbox"/> Yes ___% of operations</p> <p>Does the insured perform hardscape work? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please explain:</p> <div style="border: 1px solid black; height: 40px; margin-bottom: 10px;">[Text Here]</div>
<p>Does the insured hire day laborers? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Any Highway, Curbside, or Road Median work performed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes; what is the percentage of the total operations? ___%</p>

General Classification Evaluation:

- 1) Maximum Height exposure (including tree trimming, if applicable): _____Ft. N/A
If applicable - Method of reaching height exposures: (Check all that apply)
 Ladder Scaffolding Scissor Lifts Other: _____
 If scaffolding is used, does the insured build their own? No Yes - _____% of annual operations compared to total operations.
- 2) Maximum Weight lifted: _____ lbs. N/A
If applicable: Manual Lifting Employee(s) lifts with assistance: Please explain: _____
 Please list the typical types of items lifted: _____
- 3) Vehicle exposure: Yes No
If Yes -
 Percentage of total operations: _____% Total # of Vehicles _____
 Number of employee drivers: _____ Do employees take the vehicle home overnight? Yes No
 Driving Radius in miles: _____mi. GPS tracking system installed? Yes No
 MVR's Checked: Yes No Company Owned: Yes No
 PUC Filing: N/A Yes: _____ MCP Filing: N/A Yes: _____
- 4) Any Out of State, International, or Overnight Travel: Yes No
If Yes - Please provide:
 Number of employee's traveling: _____ Location(s): _____
 Method of transportation: _____ Frequency of travel: _____
- 5) CPR Training provided: Yes No If Yes - Number of Employees certified: _____

Claims Handling:

- 1) Is there a set procedure for reporting claims? Yes No
- 2) Is there a formal written accident investigation report? Yes No
- 3) Do you currently participate in an MPN program to control claim costs? Yes No

Personnel Practices:

- 1) New-hire orientation program: Yes No Is the orientation documented? Yes No
- 2) Owner is active in daily operations: Yes No
- 3) Employee Handbook: Yes No
- 4) Post-accident drug testing: Yes No
- 5) Job specific training: Yes No
- 6) Performance Appraisals: Yes No
- 7) Wellness program in place: Yes No
- 8) Are any of the following benefits provided?
 Medical: No Yes: Employer contribution: ____% Percentage of employees enrolled: ____%
 Retirement: No Yes: Employer contribution: ____% Percentage of employees enrolled: ____%
- 9) Any other information in regard to employee benefits? If so, please provide those details:

Employer-Employee Relationship:

- 1) Employee Turnover Rate (Annually): ____% Average Tenure of Employees (in # of years): _____
- 2) Number of employees hired:
 Full Time (annual): ____ Payroll Estimate: \$ _____
 Part Time/Seasonal: ____ Payroll Estimate: \$ _____

 No. of seasonal Employees: _____
 Seasonal Employee Period (From Month: _____ to Month: _____)

Safety Program/Practices which are implemented and enforced:

- 1) Fall Protection Plan: Yes No N/A
- 2) Heat and illness prevention program: Yes No N/A
- 3) Respiratory program: Yes No N/A
- 4) Driver safety training plan: Yes No N/A
- 5) Forklift training & safety plan: Yes No N/A
- If Yes – Annual Certification required:** Yes No N/A
- 6) MSDS available for all chemicals/products used: Yes No N/A
- 7) Written Lockout/Tag out/Block out Procedures: Yes No N/A
- 8) Hazardous chemicals safety plan: Yes No N/A
- 9) Confined spaces plan: Yes No N/A
- 10) Active safety incentive program for all employees: Yes No N/A
- 11) Are supervisors held accountable for a safe work environment? Yes No N/A
- 12) Extreme temperature program meets Cal OSHA Requirements: Yes No N/A
- 13) Is there a dedicated full time safety manager? Yes No N/A

If Yes – Please provide:

Name: _____ Title: _____

- 14) Safety meetings are conducted: Daily Weekly Monthly Quarterly Does not conduct Safety Meetings
 Are safety meetings documented? Yes No
- 15) Personal Protective equipment provide to all employees: No Yes, please list types: _____
- 16) Employee to Supervisor ratio: ____ / ____
- 17) What loss prevention recommendations has the insured implemented? Loss control service has not been performed.

Year implemented: _____
 [Text here]

Machinery and Equipment:

- 1) Please list the types of machinery/equipment used: _____ N/A
- 2) Are all equipment operators certified? Yes No
- 3) Is all machinery/equipment properly guarded: Yes No
- 4) Age of equipment in years: 0-5 5-10 10-20 20+
- 5) Condition of the equipment: Excellent Good Average Poor
- 6) Who is responsible for maintaining machinery? Insured Contractor Other: _____

Is there any other information about your company, operations, or practices you have implemented which could have an impact on mitigating injuries?

[Text here]