Manufacturing - Industry Supplemental Questionnaire

STATE COMPENSATION INSURANCE FUND®

Applicant Information:

Proposed Effective Date: / /	Legal Name:	Application ID:

Application completed by: Broker: ☐ Employer: ☐

Please provide (*first, last)* name: _______________________________ Date: ______________________________

Provide a brief description of the product manufactured:

[Text Here]

Please list the types of machinery used:

____
____
____
____

Types of machines (must equal 100%) Heavy____ % Mid____ % Light____ %

Machine Guards: ☐Point of Operation ☐Drive Mechanism

Computer Network Controlled (CNC) machinery used? Yes ☐ No ☐
if yes, percentage of all machinery considered: ____%

Lockout/Tag-out procedures in place? Yes ☐ No ☐

Does the insured do any installation of the product manufactured?
Yes ☐ No ☐

Is the building properly ventilated? Yes ☐ No ☐
Is a proper dust collection system in place? Yes ☐ No ☐

Does the insured have assembly operations? Yes ☐ No ☐
If yes, does the insured have job rotation? Yes ☐ No ☐
How many shifts in a 24-hour period? ____

General Classification Evaluation:

1) Maximum Height exposure: _____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: _____%
Number of employee drivers: _____
Driving Radius in miles: _____mi.
MVR's Checked: Yes ☐ No ☐
PUC Filing: N/A ☐Yes: __________
Total # of Vehicles_____
Do employees take the vehicle home overnight? Yes ☐ No ☐
GPS tracking system installed? Yes ☐ No ☐
Company Owned: Yes ☐ No ☐
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: ____
Method of transportation: __________________ Location(s): ________________________________
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 ☐

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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) Hazardous chemicals safety plan: Yes ☐ No ☐ N/A ☐
8) Confined spaces plan: Yes ☐ No ☐ N/A ☐
9) Active safety incentive program for all employees: Yes ☐ No ☐ N/A ☐
10) Are supervisors held accountable for a safe work environment? Yes ☐ No ☐ N/A ☐
11) Is there a dedicated full time safety manager? Yes ☐ No ☐ N/A ☐
    If Yes – Please provide:
    Name: ______________________________ Title: ______________________________
12) Safety meetings are conducted: ☐Daily ☐Weekly ☐Monthly ☐Quarterly ☐Does not conduct Safety Meetings
    Are safety meetings documented? Yes ☐ No ☐
13) Personal Protective equipment provided to all employees: No ☐ Yes, please list types:
    ____
14) Employee to Supervisor ratio: _____ / _____
15) What loss prevention recommendations has the insured implemented? ☐Loss control service has not been performed.

    Year implemented: __________

    [Text here]

Machinery and Equipment:

1) Are all equipment operators certified? Yes ☐ No ☐
2) Age of equipment in years: ☐0-5 ☐5-10 ☐10-20 ☐20+
3) Condition of the equipment: ☐Excellent ☐Good ☐Average ☐Poor
4) 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]

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