

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 provided 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]