



**EMPLOYEE BENEFITS:**

A. Is medical insurance provided? Provider:	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Are benefits provided ONLY to management and supervisors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. What percent of employees participate in a health care plan?          %	

**EMPLOYEE MANAGEMENT:**

A. Employment applications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Pre-hire screening	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Reference checks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Pre-employment physicals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Pre-employment drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Post-accident drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. For cause drug testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. A substance abuse educational program?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**EMPLOYEE PROFILE:**

Number of Employees:	
A. Number of employees with less than 1 year industry experience:	
B. Full time:	Part time:          Temporary/seasonal:          Day/casual laborers:
C. Average number of years experience: Industry: _____ With company: _____	
D. Union?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Starting hourly wage:	

**AUTOMOBILE PROFILE:**

A. Owned vehicles? If yes, are vehicles taken home at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Do employees use personal vehicles for business? If yes, what is the number of non-owned vehicles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Is there a vehicle maintenance program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Number of private passenger:    Autos                      Trucks                      Total	
E. Number of industrial trucks: (forklifts, scissor lifts, articulating boom, boom trucks)	
F. Number of drivers:                      Radius of operations:	
G. Group transportation provided? If yes, what is the maximum number of employees in vehicle at any one time:	<input type="checkbox"/> Yes <input type="checkbox"/> No

H. Fleet safety program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, check the components of the insured's program that apply:	
1. MVRs	
a. Pull notice program (if no, answer the following)	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. MVRs checked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Pre-employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Post-employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do employees receive defensive driving training?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are company automobiles parked at the business address nightly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is a formal company vehicle maintenance program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is an accident investigation and accountability program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. List the MVR acceptability standards:	<input type="checkbox"/> Yes <input type="checkbox"/> No

**EMPLOYEE SAFETY PROGRAM:**

A. Safety incentive plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Documented physical inspections of premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Formal disciplinary procedure in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Does insured provide employees with personal protective equipment or subsidize purchase?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**CLAIMS:**

Please forward loss runs for the current year and 3 years prior with a current valuation date.

For all claims over \$25,000, please advise the following:

- What was the injury?
- Description of accident
- What corrective action has the insured taken to prevent recurrence?

Current Exp Mod: \_\_\_\_\_

First prior year Mod: \_\_\_\_\_

Second prior year Mod: \_\_\_\_\_

Insured's Website: \_\_\_\_\_

Additional Information/Comments: \_\_\_\_\_

Completed By: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_