SPECTRUM
Risk Management & Insurance Services LLC
CA Lic. #0C77485

Workers Compensation Questionnaire

Business Name: **Effective Date:**

Federal Tax I.D. #: _____

Mailing Address: _____
Co. Phone#: _____ Direct #:_____ Fax#: _____

Email: _____ Contact: _____

Website: _____

Location Address: _____
Years in business: _____ Are you incorporated: _____ Gross Sales $_____

Policy Information

Policy Period 2018 : Carrier _____ Premium $ _____
Policy Period 2017 : Carrier _____ Premium $ _____
Policy Period 2016 : Carrier _____ Premium $ _____
Policy Period 2015 : Carrier _____ Premium $ _____
Policy Period 2014: Carrier _____ Premium $ _____

Class Code.	#Employees	Annual Payroll	Prior Annual Total Payroll
_____	full time: ___ pt: ____	$_____	**2018**: $_____
_____	ft: ____ pt: ____	$_____	**2017**: $_____
_____	ft:_____ pt: ____	$_____	**2016**: $_____
_____	ft:_____ pt: ____	$_____	**2015**: $_____
_____	ft:_____ pt: ____	$_____	**2014**: $_____

Officers Included/Excluded

Name	Title	Ownership %	Inc/Exc	Class Code
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Employee Benefits:

Does your company offer health insurance to employees? Yes☐ No☐

Carrier: _____

What is the % the Employer Pays? _____

Employer paid Vacation: Yes☐ No☐

Employer paid Sick Leave: Yes☐ No☐

Employee Management:

Pre-Hire Screening Yes☐ No☐

Applications & Reference Checks Yes☐ No☐

Physical Examinations Yes☐ No☐

Pre- Employment Drug Testing Yes☐ No☐

Post Accident Drug Testing Yes☐ No☐

Employee Profile:

Union: _____ Yes☐ No☐

No. of Full Time Employees: # _____ No. of Part Time Employees: #_____

Average No. of years with the Company& T/O %: _____

Any part-time or seasonal employees, is so How many: #_____ Yes☐ No☐

Percentage of Payroll for "off premises" Operations: _____ Hours of Operation: _____

Any Weekend, Nightshifts or Graveyard Shifts: Shifts: _____ Yes☐ No☐

Are sub-contractors used: _____ Yes☐ No☐

No. of company's Autos: #_____ Trucks/ Vans: # _____ Semis: #_____

No. of Drivers: #_____ Driving Radius: _____ MVR's Checked: Yes☐ No☐

Do Employees drive their Personal Autos on Company Business: Yes☐ No☐

Any work involve hazardous operations, chemicals: Yes☐ No☐

Any work performed above 20feet: How High? _____ Yes☐ No☐

Employee Safety Program:

Is there a formal safety program in operation: Yes☐ No☐

New Employee Orientation Plan: Yes☐ No☐

Employee Training Program for All Employees: Yes☐ No☐

Documented Safety Meetings with all Employees: Yes☐ No☐

Safety Incentive Plan: Yes☐ No☐

Documented Physical Inspections of Premises: Yes☐ No☐

Maximum Weight Lifted manually: Lbs_____

Controls (Back Belts, Forklifts) _____

List Mechanical Lifting Devices: _____

Machine Safety Guards in Place: Yes☐ No☐

Lockout/Tag-Out Program in Place: Yes☐ No☐

Full Time Safety Director/Risk Manager: Name: _____ Yes☐ No☐

Personal Protective Equipment provided and usage enforced: Yes☐ No☐

Written Supervisor Accountability Plan: Name: _____ Yes☐ No☐

Formal Disciplinary Procedure in Place:

Documented Accident Investigation: Yes☐ No☐

Do you have an Early Return to Work Program: Yes☐ No☐

Claims:
Please forward the following year's loss information to us:
(Valuation date should be within 90 days of the upcoming policy inception date.)

- ❑ **2019**
- ❑ **2018**
- ❑ **2017**
- ❑ **2016**
- ❑ **2015**

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

- What was the injury?
- How did it occur?
- What corrective action has the insured taken to prevent recurrence?

Current Carrier_____

Current Ins. Agency: _____

Are you currently satisfied w/t current agency and their services? Y N
Primary Concerns:

_____
_____
_____
_____

Description of Business Operations:

_____
_____
_____
_____
_____
_____

Thank you for completing the above information. Would you please return this Questionnaire and 5 years of previous loss runs? I have attached a Loss run request form for you to sign and also send back.

Thank you,

Jim Waterhouse – 949-655-1901
Spectrum Risk Management
www.spectrumrisk.com