Reset Form Print Form

Manufacturing - Industry Supplemental Questionnaire

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:	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 ☐
Please list the types of machinery used:	
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: ____ % 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: _____
   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 ☐

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: ____

Please explain...

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?