WCF INSURANCE

General Business Supplemental Questionnaire

Please Print or Type

1 Policy Information

Company	Date
Company contact person	Title
WCF agent or marketing rep.	Policy Number

2 Physical Location

Describe your business's operations (i.e. products / services, processes, distribution, etc.):

List any operation changes during the past year:

Rate your housekeeping (i.e. cleanliness / sanitation)

Poor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Exceptional

Do you have a formal machinery and equipment maintenance program? ☐ Yes ☐ No

3 Medical Facilities

Do you utilize WCF preferred provider medical facilities? ☐ Yes ☐ No

If no, are you willing? ☐ Yes ☐ No

4 Employee Hiring / Retention

Number of Current Employees:

Number of W2s Last Year:

☐ Employment Application ☐ References Verification ☐ Post-Offer Physical ☐ Drug Testing
☐ Post Accident Drug Testing ☐ Training / Orientation ☐ Other _____

Check Any Employment Benefits You Offer:

☐ Medical ☐ Dental ☐ Vision ☐ Short-term disability
☐ Long-term disability ☐ Life insurance ☐ Wellness / fitness program ☐ Sick leave
☐ Paid vacation ☐ FMLA ☐ Other _____

Other Employment Standards

☐ Employee handbook includes disciplinary policy for rule violations ☐ Conduct drug testing at random ☐ Union shop
☐ Employee handbook includes work / safety rules ☐ Conduct drug testing for cause

5 Safety

Do you have a written safety program in place? ☐ Yes ☐ No	Year Established	Name of safety director

Describe directors safety experience:

Check all elements included in your safety program

☐ Hazard communication ☐ Lockout/tagout ☐ Hearing Conservation ☐ Safety meetings
☐ Fall protection ☐ Electrical safety ☐ Excavation ☐ Equipment Operation

5 Safety (cont'd)

☐ Safety committee, describe responsibilities

☐ Incentives / contests, describe

☐ Accident investigations, title of investigator(s)

☐ Personal protective equipment, list equipment ☐ required and enforced

Describe any recent changes, additions or modifications to your safety program

Have you had any OSHA Violations in the past 5 years? ☐ Yes ☐ No
If yes, list violations

Do you have an early return to work program established? ☐ Yes ☐ No Year established Modified duty position? ☐ Yes ☐ No

6 Claims

List your three largest sources of workers compensation claims (e.g., slips and falls, cuts, ergonomics, etc.) and any preventive measure(s) you have taken:

A	Source
	Preventive measure(s)
B	Source
	Preventive measure(s)
C	Source
	Preventive measure(s)

7 Miscellaneous

List any significant changes planned for the next year

Any additional comments you consider important to this questionnaire

Print name	Signature	Date