



Named Insured:		Web Address:	
Insured's FEIN:			
CONTACT NAME		PHONE NUMBER	
Inspections:			
Premium Audit:			
Claims:			
PRIOR PAYROLL AND PREMIUM INFORMATION			
	Total Annual Payroll	Premium \$	
Current Year:			
Prior Year:			
Prior Year:			
Prior Year:			
Prior Year:			
OPERATIONS AND BENEFITS			
Broker controlled account? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does applicant currently use a PEO or payroll service? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide name of organization used:	
Please provide a detailed description of the operation:			
Years in business?		Hours of operation:	
No. of shifts:	Does the applicant allow employees to work more than three consecutive 12-hour shifts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is there a driving or delivery exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Radius of operations/travel: <input type="checkbox"/> <10 miles <input type="checkbox"/> 11-50 <input type="checkbox"/> 50-100 <input type="checkbox"/> 100+	
If yes, what is the frequency? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other:		Any group transportation of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a PUC/DMV filing required? <input type="checkbox"/> PUC <input type="checkbox"/> DMV <input type="checkbox"/> N/A		If yes, how provided? <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus	
Are vehicles company owned? <input type="checkbox"/> Yes <input type="checkbox"/> No		No. of employees transported per vehicle:	
If yes, types of vehicles:		No. of vehicles used to transport:	
If yes, are vehicles taken home: <input type="checkbox"/> Yes <input type="checkbox"/> No		Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
No. of vehicles:	No. of drivers:	Is insured enrolled in DMV Pull program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vehicle/fleet maintenance program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are driver acceptability standards in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who does the servicing?		If yes, provide details below:	
Outside vendor: <input type="checkbox"/>			
In-house mechanics: <input type="checkbox"/>			
Other: <input type="checkbox"/>			
Does insured have and enforce the following policies for drivers:			
Alcohol/drug use: <input type="checkbox"/> Yes <input type="checkbox"/> No		Seat belt use: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Distracted driving: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Any work-related injuries as a result of a prior motor vehicle accident within the past four years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details, including fault of accident and if subrogation was pursued:			
Do employees use personal vehicles for company business? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do any employees work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No		No. of employees who live/work out of state:	
		Live:	Work:
Any out-of-state, international or overnight (within state) travel? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, provide details:	
Why/purpose?			
Who will travel?	Where?	Duration?	Frequency?
No. of employees: (verify number is consistent w/ number on ACORD application)	Full:	Part:	Seasonal:
Volunteers:			
No. of employees per location:	1.	2.	3.
			4.
Use a separate page if needed.			
Average annual employee turnover: _____%		No. of W-2s issued: Last Year:	Previous Year:
How are employees paid? Hourly: <input type="checkbox"/> Piece rate: <input type="checkbox"/> Commission: <input type="checkbox"/> Flat Salary: <input type="checkbox"/> Other: <input type="checkbox"/>			
Any interchange of labor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: ___ Another business ___ Subsidiary ___ Between departments ___ Other			

Any day laborers or temporary/employee leasing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
% of union employees:	Average hourly wage for employees in governing class: \$
% of non-union:	Retirement/pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does employer contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group medical provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If group medical is provided, who is the healthcare provider?
% of employees enrolled:	% paid by employer:
Do you have a wellness program (ie encourages and promotes employee health programs) in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you provide paid sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No	Paid vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use a specific medical provider to treat injured employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently participating in a MPN (Medical Provider Network)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide the name of current MPN:	
CPR training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	RTW program? <input type="checkbox"/> Yes <input type="checkbox"/> No
No. of employees certified?	Does it include salary continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the ownership of the applicable entity changed within the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide details:	
HIRING PRACTICES - EMPLOYEE SELECTION - CLAIMS	
Written application? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-hire drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reference checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Post-accident drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Background checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	MVR checks? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre/post employment physicals? <input type="checkbox"/> Yes <input type="checkbox"/> No	Audio hearing tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic back testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a formal written accident report? <input type="checkbox"/> Yes <input type="checkbox"/> No
Formal job descriptions on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are there set procedures for reporting claims? <input type="checkbox"/> Yes <input type="checkbox"/> No
Average claim reporting time frame:	Are supervisors held accountable for injuries/accidents? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is job specific training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee Orientation Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is the orientation: <input type="checkbox"/> Verbal only? <input type="checkbox"/> Verbal and Documented?
Employee to Supervisor ratio: <input type="checkbox"/> Better than 4-1 <input type="checkbox"/> 5-1 <input type="checkbox"/> 6-1 <input type="checkbox"/> 7-1 <input type="checkbox"/> >7-1	
Subcontractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what purpose?
If yes, are certificates of insurance obtained and kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Independent contractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what purpose?
If yes, how are they paid? <input type="checkbox"/> 1099s? <input type="checkbox"/> Other? Please explain.	
SAFETY PROGRAM AND ORGANIZATION - WORK PREMISES AND ENVIRONMENT	
Are owners active in daily operations? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, are they excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Active injury & illness prevention program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has loss control services been performed in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
Active safety incentive program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Cal/OSHA visited/cited your business in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, does it encompass all employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide explanation on separate page.
What type of incentive?	Are safety meetings conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do employees receive safety training/orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other
If yes, is the training: <input type="checkbox"/> Formal / Documented <input type="checkbox"/> Informal	
Do you have a safety director or risk manager? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and title:
If yes, is the position full time or an additional responsibility of another employee?	
MSDS (Material Safety Data Sheets) available for all chemicals and products used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Any material handling exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
Any lifting exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Forklift training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, <input type="checkbox"/> <25 lbs. <input type="checkbox"/> 25-40 <input type="checkbox"/> 40+	If yes, annual certification? <input type="checkbox"/> Yes <input type="checkbox"/> No
If 40+, manual lifting or with assistance? Explain:	
Is all machinery/equipment properly guarded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Any use of Baler equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Written lockout/tagout/blockout procedures in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Condition of equipment? <input type="checkbox"/> New <input type="checkbox"/> Good <input type="checkbox"/> Average
Respiratory program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of equipment? <input type="checkbox"/> 0-5 years <input type="checkbox"/> 5-10 <input type="checkbox"/> 10-20 <input type="checkbox"/> 20+
What is the max. height in feet you'll work?	Please see Contractors Section for further elaboration.
What is used? <input type="checkbox"/> Ladder <input type="checkbox"/> Scaffolding <input type="checkbox"/> Scissor lifts <input type="checkbox"/> N/A	If scaffolding used, does the insured build their own? <input type="checkbox"/> Yes <input type="checkbox"/> No
If insured builds own scaffolding, provide % of annual operations involving scaffold setup and teardown:	
Written Fall Protection Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please see Contractors Section for further elaboration.
Are all equipment operators trained/ certified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Personal protection equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Is the building/premises: <input type="checkbox"/> Owned <input type="checkbox"/> Leased?	If yes, strict enforcement of utilization? <input type="checkbox"/> Yes <input type="checkbox"/> No
Condition of premises? <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Average	What types of PPE?
No. of years at current location?	Number of years of building occupied?

This section must be completed by all applicants who are individuals, sole proprietorships, husband and wife, or partnerships (where the general partners are husband and wife).

Please list below any relatives residing in your household who are employees of your business and to whom your books and records show payments to such relatives:

Employed Relatives*

Name	Relationship to You	Job Title or Duties	Estimated Annual Remuneration

Check here if there are no relatives residing in your household that are employed in your business.

***Relatives are defined as: spouse, child by birth or adoption, stepchild, grandchild, son-in-law, daughter-in-law, parent, step-parent, parent-in-law, grandparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, sister-in-law, uncle, aunt, nephew, or niece.**

Note: Per California Labor Code, as an employer you are required to include in your Workers' Compensation coverage all relatives residing in your household who are your employees. Any policy issued based on information provided in this application will exclude coverage for residing relatives if none are listed above.

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Arrowhead General Insurance Agency, Inc. must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Signature of Applicant:

Date:

TRUCKING

Type of authority: a.) Common carrier Contract carrier Private Brokerage Exempt

b.) Regular route Irregular route Carrier Operations: California only Interstate

Length of haul (percentages must total 100%):

Under 50 miles: _____% 51-100: _____% 101-200: _____% 201-300: _____%

301-500: _____% 501-1,000: _____% More than 1,000 _____%

Fillings: _____ DOT#: _____ PUC#: _____ DMV/MCP#: _____ Not Applicable

Please check the questions and attach the applicable data

Motor Carrier Identification Report, MCS-150: Attached or Not Applicable

Cargo Classification: See attached MCS-150 or See below (check all that apply):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> General freight | <input type="checkbox"/> Logs, poles beams, lumber | <input type="checkbox"/> Grain, feed, hay | <input type="checkbox"/> Liquids/gases |
| <input type="checkbox"/> Chemicals | <input type="checkbox"/> Household goods | <input type="checkbox"/> Building materials | <input type="checkbox"/> Intermodal containers |
| <input type="checkbox"/> Coal, coke | <input type="checkbox"/> Commodities dry bullion | <input type="checkbox"/> Metal sheets, coils, rolls | <input type="checkbox"/> Mobile homes |
| <input type="checkbox"/> Passengers | <input type="checkbox"/> Meat | <input type="checkbox"/> Refrigerated food | <input type="checkbox"/> Motor vehicles |
| <input type="checkbox"/> Machinery, Large objects | <input type="checkbox"/> Oilfield equipment | <input type="checkbox"/> Garbage, refuse, trash | <input type="checkbox"/> Beverages |
| <input type="checkbox"/> Driveway/towaway | <input type="checkbox"/> Fresh produce | <input type="checkbox"/> Livestock | <input type="checkbox"/> U.S. mail |
| <input type="checkbox"/> Paper products | <input type="checkbox"/> Other: _____ | | |

Any backhauling operations? Yes No If yes, percentage of total trips where backhauling is performed _____%

If yes, provide details on type of products backhauled:

Drivers: a) Number of drivers: _____ b) Number of owner/operators used: _____

- Percentage where the motor carrier will provide Workers' Compensation for the owner/operators: _____%

- Percentage where the motor carrier will agree with the owner/operator that the owner/operator assumes the responsibilities of an employer for the performance of work: _____%

c) If owner/operators used, please attach copy of contract: Attached or Not Applicable

d) Number of company drivers with motor carrier at least 12 months:

Number of owner/operator with motor carrier at least 12 months: _____ or Not Applicable

e) Number of Non-Union: _____ Union: _____

f) Do the drivers load and unload their trucks? Yes No

Provide detail of the materials loaded/unloaded and any equipment used:

Is the applicant enrolled in the DMV Pull Program? Yes No If so, how often?

Is the applicant enrolled in the CHP BIT Program? Yes No

Total # of trucks: _____ Trucks with sleeper cabs: _____ Single trailers: _____ Double trailers: _____ Triple trailers: _____

Any trucks/trailers with ramps? Yes No If yes, provide number:

Any trucks/trailers with lift-gates? Yes No If yes, provide number:

Any team driver operations? Yes No If yes, provide details:

If union operations, provide month/year of contract renewal: