FORESIGHT

Workers Compensation General Supplemental

Your Name	
Your Email	
Your Phone	
Your Agency	
Insured Co.	

1. Total Number of Employees: _____

   Full Time: _____ Part Time: _____ Temporary: _____

2. Is it a union shop?

   ◯ Yes ◯ No

3. Number of employees has been:

   ◯ increasing ◯ decreasing ◯ stable

4. Is group medical provided?

   ◯ Yes ◯ No

5. Is there an employer designated clinic for industrial injury?

   ◯ Yes ◯ No

6. Are there pre-employment physicals?

   ◯ Yes ◯ No

7. Are employment references checked?

_____Yes _____No

8. Is pre-employment drug screening performed?

_____Yes _____No

9. Return to light duty plan?

_____Yes _____No

10. Is there a return to full time modified work plan?

_____Yes _____No

11. Is there a formal safety program per SB198?

_____Yes _____No

Number of Employees participating _____

12. What does it consist of?

13. Is there a safety coordinator?

_____Yes _____No

14. Are safety meetings conducted?

_____Yes _____No

Name of individual conducting the meetings:

How often are safety meetings conducted?

15. Are there any unique safety measures in place?

_____Yes _____No

If yes, please specify:

16. Is there an incentive program in place?

_____Yes _____No

17. What types of job training is in place?

18. Is the insured maintaining their facilities and equipment?

_____Yes _____No

If yes, how often?

19. How does the insured address housekeeping, industrial hygiene & ergonomics issues?

20. Are all machines equipped with safety guards?

_____Yes _____No

21. Is there an aircraft or watercraft exposure?

_____Yes _____No

22. Is there any athletic sponsorship?


Yes


No

23. Do employees drive their vehicles on the job?


Yes


No

24. Does the insured run MVR's?


Yes


No