



WORKERS' COMPENSATION QUESTIONNAIRE

NAMED INSURED:			
DBA:			
ENTITY TYPE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION			
YEARS IN BUSINESS:		YEARS EXPERIENCE:	
CONTRACTORS LICENSE NUMBER:			
OWNER/PARTNER/OFFICER	D.O.B.	SOC. SEC. #	TITLE / OWNERSHIP %

FEIN NUMBER:	EMAIL:
MAILING ADDRESS:	
PHYSICAL ADDRESS:	
PHONE:	FAX:
CONTACT NAME:	

DESCRIPTION OF OPERATIONS:

PRIOR CARRIER INFORMATION		
INSURANCE COMPANY:	POLICY #:	EFF. DATE:
INSURANCE COMPANY:	POLICY #:	EFF. DATE:
INSURANCE COMPANY:	POLICY #:	EFF. DATE:

PAYROLL INFORMATION (FOR ADDITIONAL CLASS CODES PLEASE ATTACH)	
CLASS CODE:	ESTIMATED PAYROLL:
CLASS CODE:	ESTIMATED PAYROLL:
CLASS CODE:	ESTIMATED PAYROLL:
TOTAL NUMBER OF EMPLOYEES AND HOURLY WAGE:	

Section 8 – Was this operation all or part of an existing business that was purchased or acquired? Yes No, skip to Section 9

What percentage of the business was acquired?: _____ Date ownership changed: _____

Prior business owner's name and address:
 Name: _____
 Address: _____

Name of Business: _____

Is the prior owner(s) related to the new owner(s)? No Yes, Relationship: _____

Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? No Yes, please explain: _____

Were more than 50% of the current employees hired since the acquisition? Yes No
 Are those new employees earning more than 50% of the payroll? Yes No

Section 9 – Management Practices

Please indicate if you offer: Employee Assistance Program ___ Paid Vacations ___ Paid Sick Leave ___

Do you have a minimum of 2 employees? No Yes

If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) No Yes

If yes, do you pay at least 50% of the Health Insurance premium? No Yes, Name of Health Insurance Carrier: _____

Please check off the hiring practices implemented by your company: Job Descriptions ___ Pre-placement Medical Screening ___
 Pre-placement Drug Testing ___ Drug-free Workplace ___ Pre-employment Reference Check ___ Union Employees ___

Do you have an Injury and Illness Prevention Program? No Yes

Do you have a written early return-to-work program for employees injured on the job? No Yes

Do you document: Employee Training ___ Facility Inspections ___

Describe your housekeeping: Good ___ Fair ___ Poor ___ Describe the condition of your equipment: Good ___ Fair ___ Poor ___

Have you received any OSHA citations within the past year? No Yes (Please explain in "Remarks.")

Does the business provide temporary employees? No Yes (Please explain in "Remarks.")

Section 10 – Remarks (Attach a separate sheet if necessary.)

Section 11 – Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030 900561 CONTRACTORS BROKERAGE SERVICE, INC.
 BROKER ACCESS NUMBER FIRM NAME

9940 BUSINESS PARK DR. #120 SACRAMENTO CA 95827
 ADDRESS CITY STATE ZIP

(916) 368-4747 SCIF@CBSBOND.COM
 PHONE NUMBER FAX NUMBER

SIGNATURE

To be completed by the broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Name: _____ Title: _____
 Please print Please print

Signature: _____ Date: _____
 (FAXed applications must be followed up with original document/signature.)