



CID Insurance Programs, Inc.
Payroll Workers' Compensation Supplemental Questionnaire

Insured Information:

Named Insured: _____ Effective Date: _____
 FEIN# _____ Agency/Broker Firm: _____
 Phone # _____ Fax # _____ From: _____

Employee Benefits:

A. Medical Insurance: Carrier: _____
 Employer pays 80% or more of all employees Employer pays 50% or more of all employees
 Employer pays 49% or less of all employees Benefits provided only to Management and Supervisors
 No medical benefits provided
 B. Employer Paid Vacation? Yes No C. Employer paid sick leave Yes No

Employee Management:

A. Pre-hire Screening: Yes No B. Pre-Employment drug testing: Yes No
 Application Yes No C. Post Accident drug testing: Yes No

Employee Management:

A. Union Yes No
 B. Number of W-2's filed for last reporting period: _____ Starting wage/hr: \$ _____ Average wage/hr: \$ _____
 # of permanent employees: _____ # of Full Time: _____ # of Part Time: _____
 # of temporary or seasonal employees: _____ Average # of years with company: _____
 # of employees per class:
 Class: _____ # _____ Annual Payroll \$ _____
 Class: _____ # _____ Annual Payroll \$ _____
 Class: _____ # _____ Annual Payroll \$ _____
 Class: _____ # _____ Annual Payroll \$ _____
 C. Interchange of labor? (If yes, existence of physical separations?) Yes No
 D. Percent of payroll for "off premises" operations: _____ %
 E. Number of company autos: _____ Number of Drivers: _____ MVR's Checked: Yes No If yes, how often? _____
 F. Number of company trucks: _____ Number of Drivers: _____ Radius of operations: _____
 G. Do Employees drive their personal autos on Company Business: Yes No K. Early return to work program: Yes No
 H. Are employees allowed to use motorcycles on company business: Yes No L. Is the risk a restaurant: Yes No
 I. Hours of Operation: _____ M. Do they operate a micro-brewery: Yes No
 J. Any weekend, night shifts or graveyard shifts? Yes No

Employee Safety Program:

A. New employee orientation program: Yes No H. Documented physical inspection of premises: Yes No
 B. Formal written safety program: Yes No I. Maximum weight lifted manually: _____ Lbs.
 C. Documented safety meetings w/ all employees: Yes No J. Machine safety guard in place: Yes No
 D. Safety incentive plan: Yes No K. Lockout/Tag-out program in place: Yes No
 E. Written supervisor accountability plan: Yes No L. Personal protective equipment provided: Yes No
 F. Full time safety director/risk manager: Yes No M. Documented accident investigation: Yes No
 G. Employee training program for all employees: Yes No Formal disciplinary procedure in place: Yes No

Employee Payroll Trends:

A. Future staff increases: Yes No Future staff decreases: Yes No
 B. Future layoffs foreseen: Yes No

Management:

A. Owners: Active: Yes No Absentee Management: Yes No Trade Associations: _____
 B. Group transportation provided: Yes No
 C. Ration of supervisors to employees: _____: _____ Average # of years experience: _____ Number of years w/ company: _____

Claims: Please forward the following years loss information to us. Valuation date should be within 90-days of the policy inception date.

2005-2006, Carrier: _____ Payroll: \$ _____ Premium: \$ _____
 2004-2005, Carrier: _____ Payroll: \$ _____ Premium: \$ _____
 2003-2004, Carrier: _____ Payroll: \$ _____ Premium: \$ _____
 For all claims over \$25,000, please advise of the following: What the injury?, How did it occur?, What corrective action as the insured taken to prevent recurrence?

Completed By: _____, Title: _____, Date: _____