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**Supplemental  
Questionnaire**

[www.majesticinsurance.com](http://www.majesticinsurance.com)

<b>Insured Name</b>		
<b>FEIN #</b>		
<b>GENERAL MANAGEMENT</b>		
Detailed Description of Operations:		
Any Acquisitions or Ownership changes in the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer's years in business:		
Ownership: Active in Management <input type="checkbox"/> Yes <input type="checkbox"/> No		
Current number of full time employees:		
Number of part-time employees:	Number of seasonal employees:	
Number of W2's filed for latest reporting year:		
Number of employees are: <input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> Stable		
Non Union:	Union:	Union Affiliation:
Mainstream employees wages per hour: Starting \$		Average \$
Hours of Operation:	Group Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Shifts:	Frequency:	
Radius of Operations:	Mode of Transportation:	
<b>BENEFITS AND HIRING PRACTICES</b>		
Group medical provided : <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinic:	Physician:
Waiting Period for Benefits:		
Percentage paid by Employer:	# of Employees Participating:	
Dental:	Vacation:	Paid Sick Leave:
		Disability:
<b>Please mark the appropriate box (Yes/No) for each question</b>		<b>YES</b>
		<b>NO</b>
Employment Application		
References Checked		
Pre-employment Physicals		
Pre-placement Audiogram		
Drug Screening Program – Pre-placement		
Drug Screening Program - Post Accident		
Written Disciplinary Procedure In Place		
Drug/Alcohol Rehab Program		
Employee Assistance Programs		
Return to Work Program		
Does Insured Offer Modified Work		
Any Interchange of Labor		
Certificates of Insurance Obtained		
Any Sports or other Recreational Activities allowed on premises?		
Name/Title of Person Conducting Employment Interviews:		
How are qualifications of employees verified?		

## Supplemental Questionnaire

<b>Name and Title of Primary Claims Contact:</b>			
<b>SAFETY PRACTICES</b>			
<b>Name and Title of Person Responsible for Safety:</b>			
<b>Claims/Losses Incident Rate:</b>		<b>Severity Rate:</b>	
<b>Please mark the appropriate box (Yes/No) for each question</b>		<b>YES</b>	<b>NO</b>
Written Safety Program			
Safety Program Accountability			
New Employee Orientation			
Employee Safety Training (Documented)			
Substance Abuse Policy			
Hazardous Conditions Abatement Documentation			
Workplace Safety Inspections			
Smoking Allowed on Job Sites/Premises			
OCIP (Owner/Contractor Insurance Programs)			
Delivery Exposure: ____ Yes		Frequency: _____	Radius: _____
<b>CONTRACTOR'S OPERATIONS</b>			
Commercial ____ %	Industrial ____ %	Residential ____ %	Service/Repair ____ %
New ____ %	Remodel ____ %	Demolition ____ %	SubContract ____ %
<b>SPECIFIC SAFETY PROGRAMS (Please indicate if you have the following)</b>			
Back Injury Prevention Program			
Code of Safe Practices (Written and Enforced Company Safety Rules)			
Employee/Management Safety Incentive Program			
Fall Protection Program: Height Exposure _____			
Fleet Safety Program: # Vehicles _____; MVR's _____%; Company Used _____; Do you maintain your own vehicles ____ Yes ____ No			
Haz Com Program			
Lockout/Tagout Program			
Trenching Safety Program: Maximum Depth _____ Competent Person			
Management Incident Investigation			
Mobile Equipment Training Program (Forklifts – Operator Certification)			
Personal Protective Equipment Program			
<b>ANY OUT OF STATE TRAVEL?</b>			
Description of Operations:			
# of Employees: _____	Location: _____	Frequency: _____	Duration: _____
<b>HISTORICAL INFORMATION</b>			
<b>Year</b>	<b>Carrier</b>	<b>Premium</b>	<b>Total Payrolls</b>
<b>COMMENTS</b>			
<b>Completed by:</b>			<b>Date:</b>