VICTOR

WORKERS' COMPENSATION APPLICATION

In order to obtain a Workers' Compensation quotation for your company please complete the application below in its entirety and attach a four-year loss history. Email your account manager or forest.us@victorinsurance.com.

General Information

Company Name:

Location(s) _____

_____

_____

Mailing Address (if different from the above): _____

_____

_____

Contact Person: _____

Phone: **Fax:** **E-Mail:** _____

Operations:

☐ Tractor Logging ☐ Timberfalling ☐ Mechanized Logging

☐ Yarder Logging ☐ Road Construction ☐ Log Hauling

☐ Other (please specify) _____

You are a/an: ❑ Individual ❑ Partnership ❑ Corporation or ❑Other (specify) _____

Has ownership of business changed in the past three years? ☐Yes ☐No

If yes, explain: _____

Do you lease, contract, or temporarily hire employees/laborers to or from any entity? ☐Yes ☐No

If yes, please provide information: Name of outsourcing agency: _____

Please provide policy declaration or certificate of insurance from outsourcing agency, if applicable.

Has business or any owners of business declared bankruptcy? _____

Motor Carrier Filings; DMV Filing # _____

General Classification Evaluation

Company Name:
Location:
Policy Effective Date:

Classification Code	# of Employees	Estimated Annual Payroll
2702 – Logging or Lumbering (Tractor or Yarder)		
2710 – Sawmills or Shingle Mills		
2731 Planing or Moulding Mills		
2710 – Log Chipping		
2727 – Log Hauling		
5507 – Street or Road Construction		
7219 – Truckmen		
8742 – Outside Salespersons		
8810 – Clerical/Office		
Other (specify on separate sheet)		
Totals		

Employees listed under the classifications Clerical 8810 and Outside Sales 8742 cannot perform any duties listed under any other classification. 100% of duties must be clerical or sales and employees must be physically separated from other operations.

Owners and Officers:

NAME	TITLE	% OF OWNERSHIP OR VOTING STOCK HELD	EXCLUDE FROM POLICY	INCLUDE ON POLICY	CLASS CODE (REQUIRED IF COVERAGE IS REQUESTED)

Maximum height exposure: _____ Ft. ☐ N/A

If applicable, select the method of reaching height exposures: (check all that apply)

Ladder ☐ Scaffolding ☐ Scissor Lifts ☐ Other ☐ _____

Maximum weight lifted: _____ lbs. ☐ N/A

If applicable: Manual Lifting ☐ Employee(s) lifts with assistance: ☐ Please explain: _____

Please list the typical types of items lifted: _____

Vehicle exposure: Yes ☐ No ☐

If yes, please provide:

Percentage of total operations: ___% Total # of vehicles: _____

Number of employee drivers: _____ Do employees take the vehicle home overnight? Yes ☐ No ☐

Driving radius in miles: _____ miles GPS tracking system installed? Yes ☐ No ☐

MVR's checked? Yes ☐ No ☐ Company-owned? Yes ☐ No ☐

PUC Filing: N/A ☐ Yes: _____ MCP Filing: N/A ☐ Yes: _____

Any out of state, international, or overnight travel: Yes ☐ No ☐

If yes, please provide:

Number of employees traveling: _____

Method of transportation: _____

Frequency of travel: _____

Location(s): _____

CPR training provided: Yes ☐ No ☐ If yes, number of employees certified: _____

Claims Handling

If there a set procedure for reporting claims?	Yes ☐ No ☐
Is there a formal written accident investigation report?	Yes ☐ No ☐
Do you current participate in an MPN program to control claim costs?	Yes ☐ No ☐

Personnel Practices

Which of the following hiring/employment practices have been implemented?

Job references checked:	Yes ☐ No ☐	Pre-placement physical exam:	Yes ☐ No ☐
New-hire orientation program:	Yes ☐ No ☐	Is the orientation documented?	Yes ☐ No ☐
New employee training	Yes ☐ No ☐	Job specific training	Yes ☐ No ☐
Written safety program:	Yes ☐ No ☐	Disciplinary procedure:	Yes ☐ No ☐
Owner is active in daily operations:	Yes ☐ No ☐	Employee handbook	Yes ☐ No ☐
Drug testing:	Yes ☐ No ☐	Post-accident drug testing	Yes ☐ No ☐
Performance appraisals	Yes ☐ No ☐	Wellness program in place	Yes ☐ No ☐
Modified/transitional return to work program:	Yes ☐ No ☐		

Are any of the following benefits provided?

Medical:	No ☐ Yes ☐	Employee contribution: ____%
Retirement:	No ☐ Yes ☐	Employee contribution: ____%
Health & Disability Insurance:	No ☐ Yes ☐	Employee contribution: ____%
Paid Vacation:	No ☐ Yes ☐	
Paid Sick Leave:	No ☐ Yes ☐	Employee contribution: ____%

Additional information in regards to employee benefits.

_____

Employer-Employee Relationship

Employee turnover rate (annually): ____% Average tenure of employees (# of years): _____

Number of employee hired:

Full time (annual): _____ Payroll estimate: $_____

Part time: _____ Payroll estimate: $_____

Seasonal employees: _____ Seasonal employee period: From Month _____ to Month: _____

Safety Program/Practices

Which of the following programs/practices have been implemented and enforced?

Fall protection plan:	Yes ☐ No ☐ N/A ☐
Heat and illness prevention program:	Yes ☐ No ☐ N/A ☐
Respiratory program:	Yes ☐ No ☐ N/A ☐
Driver safety training plan:	Yes ☐ No ☐ N/A ☐
Forklift training and safety plan:	Yes ☐ No ☐ N/A ☐
If yes, annual certification required:	Yes ☐ No ☐ N/A ☐
MSDS available for all chemicals/products used:	Yes ☐ No ☐ N/A ☐
Written lockout/tag out/block out procedures:	Yes ☐ No ☐ N/A ☐
Hazardous chemicals safety plan:	Yes ☐ No ☐ N/A ☐
Confined spaces plan:	Yes ☐ No ☐ N/A ☐
Active safety incentive program for all employees:	Yes ☐ No ☐ N/A ☐
Are supervisors held accountable for a safe work environment:	Yes ☐ No ☐ N/A ☐
Is there a dedicated full time safety manager?	Yes ☐ No ☐ N/A ☐

If yes, please provide:

Name: _____ Title: _____

Safety meetings are conducted and documented:

Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Does not conduct safety meetings ☐

Personal protective equipment provided to all employees: No ☐ Yes ☐

If yes, please list types: _____

Employee to supervisor ratio: ___/___

Has the insured implemented loss prevention recommendations?

☐ No, loss control service has not been performed.

☐ Yes. Year implemented: _____

Explain the recommendations: _____

_____

Machinery and Equipment

List the types of machinery/equipment used: _____ N/A ☐

Are all equipment operators certified: Yes ☐ No ☐

Are all machineries/equipment properly guarded? Yes ☐ No ☐

Age of equipment in years: 0-5 ☐ 5-10 ☐ 10-20 ☐ 20+☐

Condition of the equipment: Excellent ☐ Good ☐ Average ☐ Poor ☐

Who is responsible for maintaining machinery: Insured ☐ Contractor ☐ Other ☐ _____

Sub-Contracted Work

Percentage of work sub-contracted out: _____%

Are certificates collected annually for sub-contractors? Yes ☐ No ☐

Please explain the type of work sub-contracted out: _____

_____

Is there any other information about your company, operations or practice you have implemented which could have an impact on mitigating injuries?

_____

_____

_____

Authorized Signature: _____ **Title:**_____

Print Name: _____ **Date:** _____