Reset Form Print Form

Landscaping - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date:	Legal Name:	Application ID:

Application completed by: Broker: ☐ Employer: ☐

Please provide (*first, last)* name: Date:

Please describe the type of landscaping services performed: *(i.e. Sprinkler installation, Erosion Control Excavation or trenching work, etc.)* Please list any equipment used (including tree trimming equipment):	Percentage of operations: Residential ☐% Commercial ☐% =100% Percentage of operations: Mow/Blow ☐% Landscape Design ☐% =100% Do the operations include snow removal: Yes ☐ No ☐ If yes, do the operations include snow removal from rooftops? Yes ☐ No ☐ Do the operations include Tree Trimming: No ☐ Yes ☐% of operations Does the insured perform hardscape work? Yes ☐ No ☐ If yes, please explain:
Does the insured hire day laborers? Yes ☐ No ☐	Any Highway, Curbside, or Road Median work performed? Yes ☐ No ☐ If yes; what is the percentage of the total operations? ☐%

General Classification Evaluation:

1) Maximum Height exposure (including tree trimming, if applicable): ☐Ft. ☐N/A
   If applicable - Method of reaching height exposures: (*Check all that apply)*
   Ladder ☐ Scaffolding ☐ Scissor Lifts ☐ Other: ☐
   If scaffolding is used, does the insured build their own? No ☐Yes - ☐% of annual operations compared to total operations.

2) 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:

3) Vehicle exposure: Yes ☐ No ☐
   If Yes –
   Percentage of total operations: ☐% Total # of Vehicles ☐
   Number of employee drivers: ☐ Do employees take the vehicle home overnight? Yes ☐ No ☐
   Driving Radius in miles: ☐mi. 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:

4) Any Out of State, International, or Overnight Travel: Yes ☐ No ☐
   If Yes - Please provide:
   Number of employee's traveling:
   Method of transportation: Location(s):
   Frequency of travel:

5) CPR Training provided: Yes ☐ No ☐ **If Yes -** Number of Employees certified: ☐

Claims Handling:

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

Personnel Practices:

1) New-hire orientation program: Yes ☐ No ☐ Is the orientation documented? Yes ☐ No ☐
2) Owner is active in daily operations: Yes ☐ No ☐
3) Employee Handbook: Yes ☐ No ☐
4) Post-accident drug testing: Yes ☐ No ☐
5) Job specific training: Yes ☐ No ☐
6) Performance Appraisals: Yes ☐ No ☐
7) Wellness program in place: Yes ☐ No ☐
8) Are any of the following benefits provided?
   - Medical: No ☐ Yes: Employer contribution: ____% Percentage of employees enrolled: ____%
   - Retirement: No ☐ Yes: Employer contribution: ____% Percentage of employees enrolled: ____%
9) Any other information in regard to employee benefits? If so, please provide those details:

Employer-Employee Relationship:

1) Employee Turnover Rate (Annually): ____% Average Tenure of Employees (in # of years): _____
2) Number of employees hired:
   - Full Time (annual): ____ Payroll Estimate: $_____
   - Part Time/Seasonal: ____ Payroll Estimate: $_____

   No. of seasonal Employees: _____
   Seasonal Employee Period (From Month: _____ to Month: _____)

Safety Program/Practices which are implemented and enforced:

1) Fall Protection Plan: Yes ☐ No ☐ N/A ☐
2) Heat and illness prevention program: Yes ☐ No ☐ N/A ☐
3) Respiratory program: Yes ☐ No ☐ N/A ☐
4) Driver safety training plan: Yes ☐ No ☐ N/A ☐
5) Forklift training & safety plan: Yes ☐ No ☐ N/A ☐
   If Yes – Annual Certification required: Yes ☐ No ☐ N/A ☐
6) MSDS available for all chemicals/products used: Yes ☐ No ☐ N/A ☐
7) Written Lockout/Tag out/Block out Procedures: Yes ☐ No ☐ N/A ☐
8) Hazardous chemicals safety plan: Yes ☐ No ☐ N/A ☐
9) Confined spaces plan: Yes ☐ No ☐ N/A ☐
10) Active safety incentive program for all employees: Yes ☐ No ☐ N/A ☐
11) Are supervisors held accountable for a safe work environment? Yes ☐ No ☐ N/A ☐
12) Extreme temperature program meets Cal OSHA Requirements: Yes ☐ No ☐ N/A ☐
13) Is there a dedicated full time safety manager? Yes ☐ No ☐ N/A ☐
    If Yes – Please provide:
    Name: _____ Title: _____
14) Safety meetings are conducted: ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Does not conduct Safety Meetings
    Are safety meetings documented? Yes ☐ No ☐
15) Personal Protective equipment provide to all employees: No ☐ Yes, please list types: _____
16) Employee to Supervisor ratio: ____ / ____
17) What loss prevention recommendations has the insured implemented? ☐ Loss control service has not been performed.

Year implemented: _____

Please explain...

Machinery and Equipment:

1) Please list the types of machinery/equipment used: _____ N/A ☐
2) Are all equipment operators certified? Yes ☐ No ☐
3) Is all machinery/equipment properly guarded: Yes ☐ No ☐
4) Age of equipment in years: ☐ 0-5 ☐ 5-10 ☐ 10-20 ☐ 20+
5) Condition of the equipment: ☐ Excellent ☐ Good ☐ Average ☐ Poor
6) Who is responsible for maintaining machinery? ☐ Insured ☐ Contractor ☐ Other: _____

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