

CONTRACTOR INSURANCE QUESTIONNAIRE
WE SHOP THE INSURANCE MARKET FOR YOU!



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FOR PROMPT RESPONSE, PLEASE FAX or E-MAIL TO: **(800) 807-0-FREE / Alex@BeyerInsurance.biz**

Alex Beyer (Cell Phone: (916) 412-5430)

For your Worker's Compensation Insurance Quote, please completely answer the following:

- 1) Legal Business Name: _____
- 2) DBA Name of Business (if different): _____
- 3) License #: _____ License Type: _____ Expiration Date: _____
- 4) Mailing Address: _____ City: _____ Zip: _____
- 5) Physical Address: _____ City: _____ Zip: _____
- 6) Addresses of any other Locations: _____
- 7) Bus. Ph # () _____ Fax # () _____ Cell # () _____
 E-Mail: _____
- 8) Person to Contact about Insurance: _____
- 9) Accounting Record Contact Name, Phone & e-mail (if different): _____
- 10) General Description of Type, Activities & Operations of Business: _____

11) Partners/Officers/Relatives to be Included or Excluded from coverage:

Name	BirthDay/SS#	Title/Relationship	Ownership %	Duties	INCL./EXCL.	Yearly Pay
<i>Example: John Doe</i>	<i>4/17/77/000-00-0000</i>	<i>Owner</i>	<i>100%</i>	<i>Carpenter</i>	<i>Excluded</i>	<i>\$40,000</i>

12) Separate employees by Category/Duties/Classifications and # of Full-Time & Part-Time employees and Compensation Amount (Must estimate some anticipated payroll):

Category/Duty/Classification	F/T	P/T	Estimated Annual Compensation
<i>EXAMPLE: Plumbing</i>	<i>2</i>	<i>1</i>	<i>\$60,000</i>
<i>EXAMPLE: Administrative Only/Clerical</i>	<i>1</i>	<i>0</i>	<i>\$25,000</i>

13) Have you had prior coverage? Losses? If "yes", please submit up to 5 years: YES () NO ()

Co Name	Year	Policy #	Annual Premium	# of Claims (if any)	Amount Paid

FEIN (Required) #: _____ OR, SOCIAL SECURITY # _____

14) Please answer yes or no to the following questions:

YES

NO

- | | | |
|--|-----|-----|
| a. Does the Applicant Own, operate or lease aircraft/watercraft? | () | () |
| b. Do/Have past, present or discontinued operations involve(d) in storing, treating, discharging, applying, disposing, or transporting of hazardous material? | () | () |
| c. Any work performed underground or above 15 feet? | () | () |
| d. Any work performed on barges, vessels, docks, bridge over water? | () | () |
| e. Is applicant engaged in any other type of business? | () | () |
| f. Are sub-contractors used? (If Yes, give % of work subcontracted) ___% | () | () |
| g. Is any work sublet without certificates of insurance? | () | () |
| h. Is a written Safety Program in Operation? | () | () |
| i. Any group transportation provided? | () | () |
| j. Any Employees under 16 or Over 60 Years of age? | () | () |
| k. Any seasonal employees? | () | () |
| l. Is there any volunteer or donated labor? | () | () |
| m. Any employees with physical handicaps? | () | () |
| n. Do employees travel out of state? | () | () |
| o. Are athletic teams sponsored? | () | () |
| p. Are physicals required after offers of employment are made? | () | () |
| q. Any prior coverage declined/cancelled/non-renewed (last 3 years)? | () | () |
| r. Any other insurance with State Fund, or have you applied anywhere else? | () | () |
| s. Are employee health plans provided? | () | () |
| t. Is there a labor interchange with any other business/subsidiary? | () | () |
| u. Do you lease employees to or from other employers? | () | () |
| v. Do any employees predominantly work at home? | () | () |
| w. Any tax liens or bankruptcy within the last 5 years? | () | () |
| x. Any undisputed & unpaid workers compensation premium due from you or any commonly managed or owned enterprises?
If "yes", explain including entity name(s) & policy #'s. | () | () |

Date

Your Signature

Printed Name/Title

OTHER INSURANCE COVERAGES and SERVICES OFFERED

(For a FREE, no obligation quote, whether or not you already have some of these coverages or have any renewals coming up, circle the numbers of the services listed below and we'll do our very best to get you better coverage for less!

I will contact you to talk about your needs on the services below that indicate *Yes*)

- 1) Do you need **General Liability Insurance**? _____ (We can help you obtain the best quote possible by obtaining multiple quote and having carriers compete for your business! We shop the insurance market so you don't have to!)
- 2) Commercial **Vehicle** Coverages: Do you have any autos or trucks that you would like insured?
Who is your current Insurance Carrier? _____
- 3) **Equipment/Tools** Coverages: Do you have any equipment or tools you would like insured?
Who is your current Insurance Carrier? _____
- 4) Do you need any Bid and/or Performance **Bonds**? Who is your current Bond Company? _____
- 5) Do you **own a commercial building** which will need insurance? _____
- 6) Do you need any **Builder's Risk / Course of Construction Insurance**? _____
- 7) Are you interested in **Health Insurance (Personal or Business)**? _____
- 8) Are you interested in **Disability Insurance**? _____
- 9) Are you interested in **Life Insurance, Key Man Insurance or Buy-Sell Agreements**? _____
- 10) Are you interested in **Aflac (Accident Indemnity, Cancer/Specified Illness, Dental, Specified Health, Hospital Confinement, Hospital Intensive Care, etc.)** ? _____
- 11) Are you interested in a **reading or listening list** of books and tapes that could help your business to succeed?
- 12) Would you like to talk to our corporate attorney to find out more about how to protect your business and your personal assets, and possibly save some taxes? (If you allow us to give you a free quote, this is a FREE consultation, on us!)
- 13) We are able to offer our services for lower fees because we work only with clients who are great to deal with. Do you know anyone else like yourself who might need contractors or other business insurance coverages? We'll be sure to take great care of them. Name: _____ Phone: _____

Thank You & I Look Forward to Having You As A Valued Client!

www.competitiveedge-insurance.com

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.")

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 Business Competitive Edge Insurance Services, Inc.

BROKER ACCESS NUMBER _____ FIRM NAME _____
 PO Box 1418, Lincoln, CA 95848

ADDRESS _____ CITY _____ STATE _____ ZIP _____
 (916) 434-6078 (916) 434-6092

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: _____ Please print Title: _____ Please print

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