



Workers Compensation Fund
General Business Supplemental Questionnaire

Please Print or Type

1 Policy Information	
Company	Date
Company Contact Person	Title
WCF Agent or Marketing Rep	Policy Number

2 Physical Location
Describe your business's operations (i.e. products / services, processes, distribution, etc.)
List any operation changes during the past year
Rate your housekeeping (i.e. cleanliness / sanitation) Poor 1 2 3 4 5 6 7 8 9 10 Exceptional
Do you have a formal machinery and equipment maintenance program? <input type="checkbox"/> Yes <input type="checkbox"/> No

3 Medical Facilities
Do you utilize WCF preferred provider medical facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, are you willing? <input type="checkbox"/> Yes <input type="checkbox"/> No

4 Employee Hiring / Retention	
Number of Current Employees	Number of W2s Last Year
<input type="checkbox"/> Employment Application <input type="checkbox"/> References Verification <input type="checkbox"/> Post-Offer Physical <input type="checkbox"/> Drug Testing <input type="checkbox"/> Post Accident Drug Testing <input type="checkbox"/> Training / Orientation <input type="checkbox"/> Other	
Check Any Employment Benefits You Offer	
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Short-term disability <input type="checkbox"/> Long-term disability <input type="checkbox"/> Life insurance <input type="checkbox"/> Wellness / fitness program <input type="checkbox"/> Sick leave <input type="checkbox"/> Paid vacation <input type="checkbox"/> FMLA <input type="checkbox"/> Other _____	
Other Employment Standards	
<input type="checkbox"/> Conduct drug testing for cause <input type="checkbox"/> Conduct drug testing at random <input type="checkbox"/> Employee handbook includes work / safety rules <input type="checkbox"/> Employee handbook includes disciplinary policy for rule violations <input type="checkbox"/> Union shop	

5 Safety	
Do you have a written safety program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No Year established	Name of safety director
Describe directors safety experience	
Check all elements included in your safety program	
<input type="checkbox"/> Hazard communication <input type="checkbox"/> Lockout/tagout <input type="checkbox"/> Hearing Conservation <input type="checkbox"/> Safety meetings <input type="checkbox"/> Fall protection <input type="checkbox"/> Electrical safety <input type="checkbox"/> Excavation <input type="checkbox"/> Equipment Operation	

5 Safety (cont'd)

Safety committee, describe responsibilities

Incentives / contests, describe

Accident investigations, title of investigator(s)

Personal protective equipment, list equipment required and enforced

Describe any recent changes, additions or modifications to your safety program

Have you had any OSHA Violations in the past 5 years? Yes No
If yes, list violations

Do you have an early return to work program established?

Yes No

Year established

Modified duty position?

Yes No

6 Claims

List your three largest sources of workers compensation claims (e.g., slips and falls, cuts, ergonomics, etc.) and any preventive measure(s) you have taken:

A	Source
	Preventive measure(s)
B	Source
	Preventive measure(s)
C	Source
	Preventive measure(s)

7 Miscellaneous

List any significant changes planned for the next year

Any additional comments you consider important to this questionnaire

Print Name

Signature

Date

For your protection, Utah law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in the state prison.