



866-726-8442 phone  
866-726-8443 fax

## WORK COMP QUESTIONNAIRE

### Venture Insurance Services - FAX 866-726-8443

Applicant Name: \_\_\_\_\_

Applicant DBA: \_\_\_\_\_

(In this questionnaire the Applicant is referred to as “you”)

- Physical Address: \_\_\_\_\_
- Mailing Address: \_\_\_\_\_
- Business Phone: \_\_\_\_\_ Business Fax: \_\_\_\_\_
- Year Business Started: \_\_\_\_\_ Years of Experience: \_\_\_\_\_
- Organization Type:
  - Individual: \_\_\_\_\_ Partnership: \_\_\_\_\_ Corporation: \_\_\_\_\_ Other: \_\_\_\_\_
- Contractor’s License Number: \_\_\_\_\_
- Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
- Email: \_\_\_\_\_ Web Site: \_\_\_\_\_
- Federal Tax ID Number: \_\_\_\_\_ State Tax ID # \_\_\_\_\_

1. Fully describe your operations:

2. Indicate % of work conducted in each (must equal 100% for each row):

New Construction: _____%	Remodeling _____%	Service/Repair _____%
Commercial _____%	Residential _____%	Apts/Condos/Tract _____%
Interior _____%	Exterior _____%	

3. Estimated payroll for the next policy period: (code or description only)

Class Code	Description	Annual Payroll	FT	PT	Hourly Wage

4. PAYROLL INFORMATION

Provide total payroll for the current and past three years.

Payroll and Preium History	Total Payroll	WC Premium
Current Year		
First Prior Year		
Second Prior Year		
Third Prior Year		

5. What are you annual Gross Receipts? \$ \_\_\_\_\_
6. What are your annual subcontractor costs? \$ \_\_\_\_\_
7. Does your company employ seasonal workers? Yes  No
8. Employ any relatives or family members? Yes  No   
 What is relation to owner? \_\_\_\_\_
9. Employ any minors (under age 18)? Yes  No
10. Make any cash payments to employees or subcontractors? Yes  No
11. Pay any employees by the piece? Yes  No
12. Have any operations outside of California? Yes  No
13. Member of any trade or business association? Yes  No   
 If YES, provide the name: \_\_\_\_\_
14. Has any principal of the business declared bankruptcy in the last seven years? Yes  No
15. Was this operation all or part of an existing business that was purchased or acquired? Yes  No

16. Have you received any OSHA citations within the past year? Yes  No

If YES, please explain: \_\_\_\_\_

17. Please check off the hiring practices implemented by your company:

Completed Applications Yes  No  Reference Check Yes  No

Job Descriptions Yes  No  Drug Testing Yes  No

Drug-free Workplace Yes  No  MVRs Checked Yes  No

18. If corporation, partnership or LLC provide ownership information.

Name of owner/officer/partner	Title	Percent Ownership	Duties Performed	Include or Exclude

19. OPERATIONS

Hours of operation \_\_\_\_\_ to \_\_\_\_\_

Number of days per week: \_\_\_\_\_ Number of shifts: \_\_\_\_\_

20. Any changes in Operations in the last 5 years: Yes  No

If yes, describe: \_\_\_\_\_

21. Any travel out of state Yes  No

22. BENEFITS

Does insured provide Group Medical? Yes  No , Employer contribution: \_\_\_\_\_%

What percentage of employees are covered by the plan: \_\_\_\_\_%

Waiting period: 30 days ( ) 60 days ( ) 90 days ( ) Other: \_\_\_\_\_

Name of Group Medical provider: \_\_\_\_\_

Who is eligible? All employees ( ) Only full time ( ) Other: \_\_\_\_\_

Paid Sick Leave Yes  No  Paid Vacation Yes  No  Retirement Plan Yes  No

APPLICANT'S STATEMENT

1. I hereby attest that the information contained herein is true and accurate to the best of my knowledge, information and belief.

\_\_\_\_\_  
Signature and Date