

Berkshire Hathaway Homestate Companies 2011 Supplemental Application

Insured: _____ Eff. Date: _____
 Contact Name & Title: _____ Tel. #: _____ Fax #: _____ Website Address : _____

GENERAL INFORMATION:

Years in business: _____ # of locations _____
 Description of operations _____
 Union: Yes No If yes, name of Union _____
 Current number of employees: Full time _____ Part time _____ Seasonal _____ Volunteers _____
 Percent of employee turnover in the last 12 months Full time _____ Part time _____
 Employee staffing expectation over the next 12 months Full time _____ Part time _____
 Average hourly wage in Governing Class: Full time \$ _____ Part time \$ _____
 Average hourly wage in Clerical class: Full time \$ _____ Part time _____
 Average hourly wage in Sales class: Full time \$ _____ Part time _____
 Has the insured ever been in bankruptcy? Yes No If yes, explain _____

BENEFITS:

Are ALL employees eligible Y/N; if no then who? _____

	% paid by employer	% of participation
Group Health <input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid sick leave <input type="checkbox"/> Yes <input type="checkbox"/> No	Vacation <input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement / Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No

 Name of Healthcare provider: _____
 Do you use a specific: Clinic _____ Physician _____ Emergency room _____
 CPR training provided? Yes No

SAFETY PROGRAM:

Safety program / IIPP compliant with SB 198 Yes No
 Return to light duty plan Yes No
 Return to full time modified work plan Yes No
 Designated full time safety director Yes No Name: _____
 Safety meetings held for all employees Yes No Frequency of meetings _____
 Safety training held for all employees Yes No Incentive program for employees Yes No
 Personal protective safety equipment provided Yes No
 Supervisors are held accountable for injuries / accidents Yes No
 Accident investigation program in place Yes No
 Do you have a Health & Wellness program? Yes No
 Describe Health & Wellness activities: (eg. physical fitness and nutrition assessment and consultation, lifestyle health risk appraisal, discounted gym membership, walk-at-lunch program, weight loss/smoking cessation program, stress reduction, first aid, blood pressure management, physical demand validation of job descriptions, etc.) _____

HIRING PRACTICES:

Employment application	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug/substance abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reference checks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Audiometric Testing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Motor Vehicle Record Check	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre/Post employment physical	<input type="checkbox"/> Yes <input type="checkbox"/> No
Volunteer Labor used	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pathogenic test (i.e. lead)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Temporary labor used	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic back test	<input type="checkbox"/> Yes <input type="checkbox"/> No

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OPERATIONS:

Hours of operation: _____ to _____ Number of daily shifts _____
 Operation includes driving? Yes No Number of authorized drivers _____ No. of vehicles _____
 Types of vehicles driven _____
 Reason(s) for driving (delivery, sales calls, etc.)? _____
 Frequency of driving: Daily Weekly Other
 Driving radius: < 50 miles 51-100 miles 101-250 miles 250 miles
 Frequency of MVR checks _____ Participation in CHP Pull program Yes No
 Driver acceptability standards have been established Yes No
 Vehicles inspection / maintenance program Yes No Frequency _____
 Vehicle maintenance performed is performed by employees Yes No
 Employees take vehicles home Yes No
 Motor Carrier Permit (MCP) Filing Number: _____

PAYROLL AND PREMIUM HISTORY:

Payroll: 2010	Premium: 2010
2009	2009
2008	2008
2007	2007
2006	2006

Any travel out of Country/ State? Yes No No. of employees who travel: _____ Frequency _____
 What Countries and/or States? _____
 Purpose: _____

HOTEL / MOTEL:

Number of guest rooms: _____ Room rate: Under \$50 \$50-74.95 \$75-99 Over \$100
 Food service: Operate own: Yes No Subcontract: Restaurant Bar Both
 Gross receipts: Food % _____ Liquor % _____
 Entertainment: Yes No Lounge: Yes No Armed Security: Yes No
 Operation: Year round Seasonal Conference center: Yes No
 Shuttle service: Yes No How many vans: _____
 How are maids compensated: Salary Hourly wage Flat rate per room
 Who flips the mattresses and how are they turned: _____

RETAIL / WHOLESALE:

Gross receipts: Wholesale % _____ Retail % _____ Compensation: Flat salary _____ Hourly wage _____
 Type of merchandise _____ Commission _____
 Palletized: Yes No Outside sales employees: Yes No
 Lifting exposure or repackaging: Yes No Lbs: _____ Is there assembly: Yes No If yes, what? _____
 Forklift exposures describe: _____

MANUFACTURING & ASSEMBLING:

Machine guarding: Point of operation: Yes No Material handling exposure: Yes No
 Drive mechanism: Yes No Lifting: Below 50 lbs. Above 50 lbs.
 Moving Parts: Yes No Lock out/tag out: Yes No Off premises operations: Yes No Percentage _____
 % of - Point of operation guarding: _____
 Moving parts Drive Mechanism: _____
TYPE OF MACHINES USED? _____
 Where / What: _____
 Personal Protection Equipment provided? Yes No
 Use enforced? Yes No
 Any piece-work or home-based work? Yes No
 If yes, explain: _____

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SERVICE STATIONS / AUTO REPAIR SHOPS / TRANSMISSION SHOPS:

Hours of Operation _____
 Gas operation: Full Service Self service
 Repair operation: Yes No
 Tire repair/installation Over 1-ton truck (yes/no)
 Towing: Yes No Contract tow: Yes No
 Road Repair: Yes No
 Mini-Market: Yes No Liquor sold? Yes No
 Bullet proof cashier booth: Yes No
 Drop safe or registers: Yes No
 Car Wash: Yes No *If yes,* self serve full serve
 Access to freeway: 0-1 mile 1-2 miles 2+ miles

ATTORNEYS

What type of law:
 Any criminal law: Yes No Percentage Any insurance law: Yes No Percentage

RESTAURANT:

Average Entrée Price: _____ Separate Lounge: Yes No
 Liquor Receipts (% of gross receipts) _____ Twenty-four hour operation: Yes No
 Entertainment: Yes No If yes, please provide details: _____ Multiple Floor levels: Yes No
 Catering: Yes No % of revenues: _____ Number of: Hosts Valet Parkers
 Radius: _____ Waitpersons Bartenders
 Delivery: Yes No % of revenues: _____ Cooks Take-out: Yes No
 Radius: _____

APARTMENT OWNER OR OPERATOR:

List of operations sub-contracted to others: _____
 Current employees perform sub-contracted operations for you? Yes No *If yes, please list:*
 The following items are maintained and kept current for all sub-contractors:
 Certificate of workers' compensation insurance Yes No
 Copy of each sub-contractor's license number Yes No

JANITORIAL:

Percentage of revenues from: Office Buildings Manufacturing Plants Medical Properties Other
 Pressure cleaning? Yes No Concrete cleaning or sealing? Yes No Roof or gutter cleanup? Yes No
 Window Washing requiring ladder or other device for heights Yes No Large Debris hauling Yes No
 Other work requiring ladders Yes No Multiple Locations per night Yes No Group Transportation Yes No
 Confined Space (vents, etc) Yes No Buffing waxing carpet cleaning Yes No

FARMING OPERATIONS:

Row Crops: % Trees/Vines: % Dairy/Cattle: %
 Is housing provided? Yes No If yes, how many employees?
 How many acres: 160 or less 161-499 500-999 1000+
 Transportation of employees: Yes No If yes, how: Van Bus Other ; Frequency: Daily Weekly Monthly Radius
 Use Labor Contractor? Yes No
 How are employees paid? Hourly rate Piece rate Combination Other
 Dairy Barn: Elevated Carousel Flat Other
 Number of milking cows _____
 Number of bulls _____ Number of bulls 3 years and older _____
 Outside Veterinary Services Yes No
 • Artificial Insemination: Yes No Subcontracted? Yes No
 • Hoof trimming: Yes No Subcontracted? Yes No
 • De-horning: Yes No Subcontracted? Yes No
 • Does insured harvest for others? Yes No If yes, own equipment used? Yes No

Alcoholic and Drug Recovery Homes, Social Rehabilitation Facilities for Adults, Nursing Homes, Convalescent Homes or Convalescent Hospitals, Rest Homes, Sanitariums, Congregate Living Facilities for the Elderly, Hospitals, Residential Care Facilities for the Elderly, Residential Care Facilities for the Adults, Residential Care for the Developmentally Disabled

Are the Insured facilities licensed? Yes No

If yes, by whom: California Department of Social Services, or _____.

Occupancy

	No. of Beds Certified	Current Census	Level of Care	Current Census
Medicare/Medicaid	<input type="text"/>	<input type="text"/>	Skilled	<input type="text"/>
Private Pay	<input type="text"/>	<input type="text"/>	Intermediate	<input type="text"/>
Total Beds	<input type="text"/>	<input type="text"/>	Independent Living	<input type="text"/>
			Total Beds	<input type="text"/>

Indicate the number of beds provided for residents with the following (included in the totals above)

Alzheimer/dementia chemical dependency
 HIV patients mental retardation/ mental illness

Average census past 12 months for all residents:

Describe other services:

Home health care? yes no
 Adult day care? yes no

Percentage (%) of ambulatory patients?

Employees

EMPLOYEE BREAKDOWN

	<u>Full Time</u>	<u>Part Time</u>		<u>Full Time</u>	<u>Part Time</u>
Management			Physical Therapy		
Clerical			Dietary		
RN's			Maintenance		
LPN's			Laundry		
CNA's			Other		
			Totals		

In past 12 months, how often has a Temporary Agency been used to meet staffing needs? yes no

Signed by:

Title:

Dated: