

**MISSOURI PUBLIC ENTITY RISK MANAGEMENT FUND
EXPOSURE QUESTIONNAIRE - GENERAL INFORMATION**



2010 Williams St.
P.O. Box 105080
Jefferson City, MO 65110-5080
(573) 751-1437
FAX (573) 751-8276

PLEASE ATTACH SEPARATE PAGE TO EXPLAIN ANSWERS, IF NECESSARY

AGENT'S NAME (IF APPLICABLE)		AGENCY NAME		PHONE NUMBER	
ADDRESS		CITY		STATE	
				ZIP CODE	

1. NAME OF ENTITY _____

2. MAILING ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

3. NAME AND TITLE OF CONTACT PERSON _____ 4. PHONE NUMBER _____ 5. PROPOSED EFFECTIVE DATE _____

6. TYPE OF ENTITY _____ 7. COUNTY _____ 8. POPULATION OF AREA SERVICED _____

9. AUTHORIZED SIGNATURE _____ 10. NUMBER OF OFFICIALS ON YOUR GOVERNING BOARD _____

	ACTUAL (PREVIOUS FISCAL YEAR)	BUDGET (CURRENT FISCAL YEAR)
11. GROSS REVENUES/INCOME	\$ _____	\$ _____
12. EXPENDITURES*	\$ _____	\$ _____
13. TOTAL PAYROLL	\$ _____	\$ _____
14. NUMBER OF EMPLOYEES	_____	_____

*EXPENDITURES IS DEFINED AS TOTAL OPERATING COSTS/EXPENDITURES WITHOUT REGARD TO THE SOURCE OF REVENUE DURING THE FISCAL YEAR PERIOD EXCLUDING:

- 1. CAPITAL IMPROVEMENTS/BONDABLE ITEMS INCLUDING THE INTEREST THEREIN, NEW CONSTRUCTION, MAJOR IMPROVEMENTS AND PURCHASE OF LAND OR DEVS.
- 2. EXPENDITURES FOR INDEPENDENT CONTRACTORS OPERATIONS.
- 3. RETIREMENT BENEFITS (NOT ADMINISTRATIVE COSTS).
- 4. PAYROLL

15. DO YOU OWN OR OPERATE ANY WATERCRAFT OR AIRCRAFT? YES NO IF YES, LIST AND EXPLAIN PURPOSE:

16. NUMBER OF ADMINISTRATIVE BUILDINGS: _____

17. NUMBER OF WAREHOUSES, GARAGES, EQUIPMENT YARDS _____

18. DESCRIBE EXHIBITIONS OR OTHER SPECIAL EVENTS THAT YOU SPONSOR _____

19. INCLUDE EMPLOYEE BENEFIT LIABILITY YES NO

20. CURRENT CARRIER INFORMATION	LIMITS	PREMIUM	DEDUCTIBLE	TYPE OF COVERAGE**
	GENERAL LIABILITY			
AUTOMOBILE COVERAGES				
PUBLIC OFFICIALS ERRORS & OMISSIONS				
LAW ENFORCEMENT				

**CLAIMS - MADE OR OCCURRENCE FORM. IF CURRENT COVERAGE IS WRITTEN ON A CLAIMS-MADE BASIS, PLEASE SPECIFY RETROACTIVE DATE: _____

21. GENERAL EXPOSURES: DO YOU OWN OR OPERATE?					
	YES	NO		YES	NO
AIRCRAFT			LEVEES/DRAINAGE DISTRICTS * (J)		
AIRPORT			MEDICAL FACILITIES * (K)		
AMBULANCE SERVICE * (A)			MUSEUM OR LIBRARY		
AMUSEMENT PARKS			RECREATIONAL FACILITIES		
BEACH OR LAKES			PARKS & PLAYGROUNDS * (D)		
BLASTING OPERATIONS * (B)			SWIMMING POOLS * (D)		
BRIDGES * (B)			GOLF COURSES * (D)		
CEMETERIES			REFUSE REMOVAL * (I)		
CHEMICAL SPRAYING			SCHOOLS		
DAMS/RESERVOIRS			SEWER DEPARTMENT * (E)		
FAIRS, CARNIVALS, FESTIVALS			STADIUMS OR GRANDSTANDS		
FIRE DEPARTMENT * (A)			STREET OR ROAD MAINTENANCE * (B)		
FIREWORKS EXHIBITIONS			TRANSPORTATION SYSTEM		
HEALTH DEPARTMENT * (K)			UTILITIES		
HOUSING AUTHORITY			ELECTRICAL * (H)		
ICE/SKATING RINKS			GAS * (G)		
JAIL/HOLDING CELLS * (C)			WATER * (F)		
LANDFILL * (I)			PLANNING & ZONING BOARD		
LAW ENFORCEMENT * (C)			OTHER		

(A-K) IF YES, PLEASE COMPLETE APPROPRIATE SECTIONS THAT FOLLOW

SCHOOLS AND TRANSPORTATION SERVICES REQUIRE A SEPARATE QUESTIONNAIRE. PLEASE CONTACT OUR OFFICE AT (573) 751-1837 FOR THE CORRECT QUESTIONNAIRE.

(A) FIRE AND/OR AMBULANCE SERVICE QUESTIONNAIRE

1. RADIUS OF OPERATIONS: _____

2. PERSONNEL (NUMBER)	PAID	VOLUNTEER
EMT'S	_____ F.T.E.	_____ F.T.E.
PARAMEDICS	_____ F.T.E.	_____ F.T.E.
FIREFIIGHTERS	_____ F.T.E.	_____ F.T.E.
OTHER-	_____ F.T.E.	_____ F.T.E.

DESCRIBE: _____

(F.T.E. - FULL TIME EQUIVALENCY BASED ON 40 HOURS PER WEEK)

3. NUMBER OF CALLS RESPONDED TO LAST YEAR _____

IF YOUR RECORDS SHOW CALLS BY CATEGORY, SHOW THAT INFORMATION _____

4. DESCRIBE THE SCOPE OF YOUR SERVICES (E.G. FIRE FIGHTING, BUILDING INSPECTION, FIRE PREVENTION AND SAFETY TRAINING, SEARCH AND RESCUE OPERATIONS, AMBULANCES AND PARAMEDIC OPERATIONS, ETC.) _____

5. ARE YOU UNDER CONTRACT TO OTHERS OR ARE THEY UNDER CONTRACT TO YOU (E.G. HOSPITALS, DOCTORS)?

YES NO IF YES, DESCRIBE _____

(B) ROAD, BRIDGE AND BLASTING OPERATIONS QUESTIONNAIRE

1. MILEAGE OF ROADS/STREETS OWNED, CONTROLLED OR SERVICED BY YOU _____
2. DO YOU BUILD ROADS? YES NO IF YES, DESCRIBE OPERATIONS _____

3. DO YOU BUILD, MAINTAIN OR REPAIR BRIDGES? YES NO IF YES, DESCRIBE TYPE OF CONSTRUCTION (STEEL, CONCRETE, ETC.) _____

4. DESCRIBE ANY UNDERGROUND OPERATION EXPOSURES (MINES, TUNNELS, ETC.) _____

5. DESCRIBE IN DETAIL ANY BLASTING ACTIVITIES _____

(C) LAW ENFORCEMENT QUESTIONNAIRE

1. PERSONNEL (NUMBER)
DISPATCHERS _____ F.T.E.
JAILERS _____ F.T.E.
OFFICERS _____ F.T.E. (WITH ARREST POWERS)
RESERVES _____ F.T.E.
K-9 UNIT _____ F.T.E.
(F.T.E. - FULL TIME EQUIVALENCY BASED ON 40 HOUR WEEK)
2. DO ALL OFFICERS MEET THE MINIMUM TRAINING REQUIREMENTS ESTABLISHED BY THE STATE? YES NO
3. DO YOU OWN OR OPERATE A FIRING RANGE? YES NO IF YES, DESCRIBE _____

4. ARE JAIL FACILITIES MAINTAINED? YES NO TOTAL SQUARE FEET _____
NUMBER OF CELLS _____ AREA OF EACH CELL (SQ. FT.) _____
TOTAL NUMBER OF BEDS _____ BEDS PER CELL _____
AVERAGE NUMBER OF INMATES INCARCERATED _____
ARE JUVENILES HOUSED SEPARATELY? YES NO
NUMBER OF JAILERS ON DUTY EACH SHIFT _____
DOES DISPATCHER SERVE AS JAILER? _____
WHAT METHOD IS USED FOR INMATE SURVEILLANCE? _____
ARE STRIP SEARCHES PERFORMED? YES NO
LIST AND BRIEFLY DESCRIBE ANY CLAIMS/SUITS WHICH HAVE AROSE FROM OPERATION OF THE JAIL:

(D) RECREATIONAL FACILITIES QUESTIONNAIRE

1. HOW MANY PARKS ARE OWNED BY THE ENTITY? _____ APPROXIMATE NO. OF ACRES _____
IS PLAYGROUND EQUIPMENT INSPECTED? YES NO
2. ATTACH A LIST OF ATHLETIC EVENTS SPONSORED BY THE ENTITY AND THE APPROXIMATE NUMBER OF PARTICIPANTS IN EACH EVENT.
3. NUMBER OF GOLF COURSES _____ ANNUAL RECEIPTS \$ _____
NUMBER OF GOLFMOBILES _____ ANNUAL RECEIPTS \$ _____
4. NUMBER OF SWIMMING POOLS _____ NUMBER OF DIVING BOARDS _____
IS THE AREA SURROUNDING THE POOL(S) FENCED? YES NO
ARE CERTIFIED LIFEGUARDS ON DUTY AT ALL TIMES WHEN THE POOL IS OPEN? YES NO
ARE POOL(S) DRAINED IN THE OFF SEASON? YES NO ARE POOL REGULATIONS POSTED? YES NO

(E) SEWER OPERATIONS QUESTIONNAIRE

1. IS A SEWAGE DISPOSAL PLANT MAINTAINED? YES NO
IF NO, WHAT DISPOSAL METHODS ARE USED? _____
IF YES, BY YOU OR INDEPENDENT CONTRACTOR? _____
2. WHAT PERCENTAGE OF SEWAGE TREATMENT IS PERFORMED BY YOU? _____
BY INDEPENDENT CONTRACTORS? _____
3. WHAT PERCENTAGE OF CONSTRUCTION IS PERFORMED BY YOU? _____
BY INDEPENDENT CONTRACTORS? _____
4. NUMBER OF MILES OF SEWER LINES MAINTAINED? _____
5. IS THERE A PREVENTATIVE MAINTENANCE SCHEDULE? YES NO
IF YES, DESCRIBE: _____

6. HOW OLD IS THE SYSTEM, INCLUDING LINES? _____
7. ARE LIFT STATIONS IN OPERATION? YES NO
8. ARE BACK FLOW VALVES REQUIRED? YES NO
9. LIST AND BRIEFLY DESCRIBE ANY CLAIMS/SUITS WHICH HAVE ARISEN FROM OPERATION OF THE SEWER SYSTEM:

10. IF WORK IS BEING PERFORMED BY YOUR EMPLOYEES, WHAT TRAINING IS REQUIRED OF THEM?

(F) WATER UTILITY QUESTIONNAIRE

- 1. NUMBER OF EMPLOYEES _____ 2. ANNUAL DISTRIBUTION (GALLONS) _____
- 3. SOURCE OF WATER SUPPLY _____
- 4. IS PIPE INSTALLATION PERFORMED BY: DISTRICT OR INDEPENDENT CONTRACTORS?
- 5. WHAT TYPE OF PIPE IS USED? _____
- 6. HOW OLD IS SYSTEM? _____
- 7. HOW OFTEN IS DRINKING WATER TESTED? _____
- 8. IS A FLUORINE COMPOUND USED IN THE WATER? YES NO
HOW IS IT CONTROLLED? _____
- 9. WATER SUPPLY TANKS (ATTACH SEPARATE PAGE IF NÉCESSARY)

CONSTRUCTION	TYPE	CAPACITY (GALLONS)	AGE

- 10. IS TANK BASE FENCED? YES NO IS AREA LIGHTED? YES NO
- 11. HOW OFTEN ARE TANKS INSPECTED? _____ BY WHOM? _____
- 12. ARE THERE ANY DAMS, LEVEES, DIKES OR RESERVOIRS? YES NO

(G) GAS UTILITY QUESTIONNAIRE

- 1. GROSS REVENUE _____ ANNUAL PAYROLL _____
NUMBER OF EMPLOYEES _____
- 2. DO YOU DRILL WELLS? YES NO DO YOU OPERATE ANY WELLS? YES NO
- 3. DO YOU CONSTRUCT PIPELINES YES NO DO YOU MAINTAIN ANY PIPELINES? YES NO
- 4. NUMBER OF CUSTOMERS BY CLASSIFICATION
RESIDENTIAL _____ COMMERCIAL _____ INDUSTRIAL _____ OTHER _____
- 5. TOTAL AMOUNT OF GAS SOLD IN THE LATEST FISCAL YEAR (GALLONS)
- 6. UNACCOUNTED FOR GAS AMOUNTED TO _____ % OF THE TOTAL AMOUNT OF GAS PURCHASED BY THE GAS UTILITY IN THE LATEST FISCAL YEAR.
- 7. DESCRIBE YOUR OPERATIONS, INCLUDING INFORMATION ON GAS SUPPLIERS, PIPELINES, ODORIZING STATIONS, PROPANE SALES, REPAIR OR SERVICE OF CUSTOMER'S APPLIANCES OR ANY OTHER WORK BEYOND THE CUSTOMER'S METER _____

- 8. ATTACH COPY OF YOUR MOST RECENT ANNUAL REPORT TO THE UNITED STATES DEPARTMENT OF TRANSPORTATION.

(H) ELECTRIC UTILITY QUESTIONNAIRE

1. GROSS REVENUE _____ ANNUAL PAYROLL _____
 NUMBER OF EMPLOYEES _____ NUMBER OF CUSTOMERS _____
2. DO YOU PERFORM? POLE INSTALLATION YES NO SERVICE CONNECTION YES NO
 TRANSFORMER INSTALLATION YES NO WIRE STRINGING YES NO METER READING YES NO
3. NUMBER OF POWER SOURCES _____ PERCENTAGE OF POWER GENERATED BY ENTITY _____ %
 LOCATION OF POWER PLANT _____
4. DO YOU DISTRIBUTE POWER PURCHASED FROM ANOTHER SOURCE? _____
 IF PURCHASED, ANNUAL COST: _____

IF YOUR ENTITY GENERATES POWER, PLEASE COMPLETE THE FOLLOWING

5. POWER GENERATION

LOCATION	TYPE OF FUEL	GENERATING CAPACITY IN KILOWATTS	% OF TOTAL GENERATING CAPACITY

6. HIGH VOLTAGE TRANSMISSION: NUMBER OF TOWERS _____ NUMBER OF LINE MILES _____
7. IS YOUR ENTITY PART OF A REGIONAL GRID OR POWER POOL? YES NO IF YES, DESCRIBE _____

8. NUMBER OF CUSTOMERS BY CLASSIFICATION
 RESIDENTIAL _____ COMMERCIAL _____ INDUSTRIAL _____ OTHER _____
9. LIST ANY CUSTOMERS ACCOUNTING FOR MORE THAN 5% OF TOTAL OUTPUT _____

(I) REFUSE REMOVAL OPERATIONS QUESTIONNAIRE

1. DESCRIBE REFUSE REMOVAL PROCEDURES, IF ANY _____

2. OWNED OR OPERATED REFUSE/DUMP/LANDFILL SITES
 A. TOTAL NUMBER IN OPERATION _____ CLOSED _____
 B. TOTAL AREA IN ACRES - OPEN _____ CLOSED _____
 C. EPA RATINGS IF APPLICABLE - OPEN SITES _____ CLOSED SITES _____
3. DO YOU HANDLE CHEMICALS OR TOXIC WASTE DISPOSAL? YES NO IF YES, DESCRIBE PROCEDURES EMPLOYED BY YOU OR YOUR INDEPENDENT CONTRACTORS _____

4. DESCRIBE ANY CHEMICAL OR TOXIC WASTE DISPOSAL FACILITY OWNED OR OPERATED BY YOU. INCLUDE EPA RATINGS _____

(J) LEVEE AND DRAINAGE DISTRICTS QUESTIONNAIRE

1. TOTAL MILES OF LEVEES MAINTAINED? _____

2. LIST FLOOD CONTROL LEVEES

NAME OF CHANNEL	CAPACITY	NUMBER OF MILES	FENCED?	
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO
			<input type="checkbox"/> YES	<input type="checkbox"/> NO

3. LIST DRAINAGE CHANNELS _____

NAME OF CHANNEL	FEET			FENCED?	
	WIDTH	DEPTH	LENGTH		
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO

4. OPEN CANALS OR WATERWAYS

FENCED _____ MILES NOT FENCED _____ MILES

5. DO YOU USE EXPLOSIVES OR DO ANY BLASTING? YES NO IF YES, DESCRIBE ACTIVITIES _____

6. PROVIDE A BRIEF DESCRIPTION OF YOUR OPERATIONS _____

(K) MEDICAL FACILITIES/HEALTH CENTERS

1. DO YOU OWN OR OPERATE ANY CLINICS OR HEALTH CENTERS? YES NO IF YES,
NUMBER OF OUTPATIENT VISITS ANNUALLY _____ (PLEASE ATTACH LIST SHOWING BREAKDOWN
BY TYPE OF VISIT.)

LIST SATELLITE LOCATIONS _____

HOME HEALTH CARE - NUMBER OF VISITS ANNUALLY _____

OUTSIDE IMMUNIZATION PROGRAMS - NUMBER ADMINISTERED _____

BRIEFLY DESCRIBE FACILITIES OR PROGRAMS OR ATTACH DESCRIPTIVE MATERIAL

2. DO YOU OPERATE ANY OF THE FOLLOWING PROGRAMS OR FACILITIES?

	LOCATION
NURSING HOMES	
CONVALESCENT HOMES	
HOMES FOR THE AGED	
FOSTER HOME PROGRAMS	
ORPHANAGES	
DRUG AND ALCOHOL REHABILITATION PROGRAMS	
SANITARIUMS/ASYLUMS	
HOMES FOR RETARDED CITIZENS	
SHELTERED WORKSHOPS	

OTHER - DESCRIBE _____

ATTACH A PAGE WHICH DESCRIBES THE PROGRAM(S) AND/OR FACILITY(IES) OPERATED.
FACILITY/PROGRAM DETAILS. PROVIDE THE FOLLOWING INFORMATION AS APPLICABLE.

TYPE OF FACILITY/PROGRAM	NUMBER OF AVAILABLE BEDS	NUMBER OF INPATIENT DAYS	NUMBER OF OUTPATIENTS

3. NON-PHYSICIAN PERSONNEL (EMPLOYED AND CONTRACTED) - SHOW NUMBER OF PERSONS IN FULL TIME EQUIVALENTS (FTE) BASED ON 40 HOUR WEEK.

	EMPLOYED # PERSONS	CONTRACTED # PERSONS
PHYSICIAN ASSISTANT		
PSYCHOLOGIST		
REGISTERED NURSE		
LICENSED PRACTICAL NURSE		
NURSE PRACTITIONER		
CERTIFIED NURSE AID		
LAB TECHNICIANS		
X-RAY TECHNICIANS		
X-RAY THERAPISTS		
NUCLEAR MEDICINE TECHNICIANS		
PHYSICAL THERAPISTS		
PHARMACISTS		
RESPIRATORY THERAPISTS		
EMERGENCY MEDICAL TECHNICIANS		
SOCIAL WORKERS		
DIETICIANS		
OTHER - DESCRIBE		

PHYSICIANS, DENTISTS AND PSYCHIATRISTS ARE EXCLUDED FROM COVERAGE.

AUTOMOBILE COVERAGES

PLEASE PROVIDE INFORMATION FOR ALL AUTOMOBILES (INCLUDING TRAILERS, IF PHYSICAL DAMAGE COVERAGE IS DESIRED). ATTACH ADDITIONAL PAGES IF NECESSARY.

ALL AUTOMOBILES AND TRAILERS WILL BE INCLUDED FOR LIABILITY COVERAGE. COMPLETE THE PHYSICAL DAMAGE AND OTHER COVERAGE SECTIONS AS DESIRED. PHYSICAL DAMAGE DEDUCTIBLES ARE AVAILABLE AT INCREMENTS OF \$100, \$250, \$500, \$1,000 AND \$3,000.

DESCRIPTION		COVERAGE AND DEDUCTIBLE				
COVERED VEHICLE NUMBER	YEAR, MODEL, TRADE NAME, BODY TYPE, VEHICLE I.D. NUMBER (VIN) (BUSES AND VANS, SHOW PASSENGER SIZE)	COST NEW	COMPREHENSIVE	COLLISION	UNINSURED MOTORISTS \$50,000	AUTO MED. PAY \$5,000
			IF COVERED, SHOW DEDUCTIBLE AMOUNT IF NOT COVERED, SHOW "NC"		SHOW "C" FOR COVERED "NC" FOR NOT COVERED	
___ 1						
___ 2						
___ 3						
___ 4						
___ 5						
___ 6						
___ 7						
___ 8						
___ 9						
___ 0						

