

Hotel / Motel - Industry Supplemental Questionnaire

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicant Information:

Proposed Effective Date: / /	Legal Name:	Application ID:
Application completed by: Broker: <input type="checkbox"/> Employer: <input type="checkbox"/>		
Please provide (first, last) name: _____		Date: _____
Which of the following best describes the risk's operations? <input type="checkbox"/> Hotel <input type="checkbox"/> Hotel/Casino <input type="checkbox"/> Motel <input type="checkbox"/> Bed/Breakfast <input type="checkbox"/> Timeshare – Brand name: _____ <input type="checkbox"/> Other: _____		Any Restaurant/Food Services? Yes <input type="checkbox"/> No <input type="checkbox"/> 24-hour room service? Yes <input type="checkbox"/> No <input type="checkbox"/> Is there a Bar, Lounge, or Night Club? Yes <input type="checkbox"/> No <input type="checkbox"/> Any entertainment provided? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain: <div style="border: 1px solid black; padding: 5px; min-height: 100px;"> <p>[text here]</p> </div>
How many guest rooms? _____ How many floors does the building have? _____ Who flips the mattresses? _____ How are the mattresses turned? _____		Do the employees have access to an elevator? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the insured provide shuttle service? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide service hours: _____ <input type="checkbox"/> 24/7
Do the employees have the ability to store cleaning equipment on each floor? Yes <input type="checkbox"/> No <input type="checkbox"/>		

General Classification Evaluation:

- 1) Maximum Height exposure: _____ Ft. N/A
If applicable - Method of reaching height exposures: *(Check all that apply)*
 Ladder Scaffolding Scissor Lifts Other: _____

 If scaffolding is used, does the insured build their own? No Yes - _____% of annual operations compared to total operations.
- 2) Maximum Weight lifted: _____ lbs. N/A
If applicable: Manual Lifting Employee(s) lifts with assistance: Please explain: _____
 Please list the typical types of items lifted: _____
- 3) Vehicle exposure: No Yes
If Yes –
 Percentage of total operations: _____% Total # of Vehicles _____
 Number of employee drivers: _____ Do employees take the vehicle home overnight? Yes No
 Driving Radius in miles: _____ mi. GPS tracking system installed? Yes No
 MVR's Checked: Yes No Company Owned: Yes No
 PUC Filing: N/A Yes: _____ MCP Filing: N/A Yes: _____
- 4) Any Out of State, International, or Overnight Travel: Yes No
If Yes - Please provide:
 Number of employee's traveling: _____ Location(s): _____
 Method of transportation: _____ Frequency of travel: _____
- 5) CPR Training provided: Yes No **If Yes** - Number of Employees certified: _____

Claims Handling:

- 1) Is there a set procedure for reporting claims? Yes No
- 2) Is there a formal written accident investigation report? Yes No
- 3) Do you currently participate in an MPN program to control claim costs? Yes No

Personnel Practices:

- 1) New-hire orientation program: Yes No Is the orientation documented? Yes No
- 2) Owner is active in daily operations: Yes No
- 3) Employee Handbook: Yes No
- 4) Post-accident drug testing: Yes No
- 5) Job specific training: Yes No
- 6) Performance Appraisals: Yes No
- 7) Wellness program in place: Yes No
- 8) Are any of the following benefits provided?
 Medical: No Yes: Employer contribution: _____% Percentage of employees enrolled: _____%
 Retirement: No Yes: Employer contribution: _____% Percentage of employees enrolled: _____%
- 9) Any other information in regard to employee benefits? If so, please provide those details:

Employer-Employee Relationship:

- 1) Employee Turnover Rate (Annually): _____% Average Tenure of Employees (in # of years): _____
- 2) Number of employees hired:
 Full Time (annual): _____ Payroll Estimate: \$ _____
 Part Time/Seasonal: _____ Payroll Estimate: \$ _____

 No. of seasonal Employees: _____
 Seasonal Employee Period (From Month: _____ to Month: _____)

Safety Program/Practices which are implemented and enforced:

- 1) Fall Protection Plan: Yes No N/A
- 2) Heat and illness prevention program: Yes No N/A
- 3) Do you maintain a written Workplace Violence Prevention Plan? Yes No N/A
- 4) Respiratory program: Yes No N/A
- 5) Driver safety training plan: Yes No N/A
- 6) Forklift training & safety plan: Yes No N/A
 If Yes – Annual Certification required: Yes No N/A
- 7) MSDS available for all chemicals/products used: Yes No N/A
- 8) Written Lockout/Tag out/Block out Procedures: Yes No N/A
- 9) Hazardous chemicals safety plan: Yes No N/A
- 10) Confined spaces plan: Yes No N/A
- 11) Active safety incentive program for all employees: Yes No N/A
- 12) Are supervisors held accountable for a safe work environment? Yes No N/A
- 13) Is there a dedicated full time safety manager? Yes No N/A

If Yes – Please provide:

Name: _____ Title: _____

- 14) Safety meetings are conducted: Daily Weekly Monthly Quarterly Does not conduct Safety Meetings
 Are safety meetings documented? Yes No
- 15) Personal Protective equipment provide to all employees: No Yes, please list types: _____
- 16) Employee to Supervisor ratio: _____ / _____
- 17) What loss prevention recommendations has the insured implemented? Loss control service has not been performed.

Year implemented: _____
 Please explain:

Is there any other information about your company, operations, or practices you have implemented which could have an impact on mitigating injuries?

[Text here]

