

Hotel / Motel - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date: / /	Legal Name:	Application ID:
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Application completed by: Broker: Employer:

Please provide (first, last) name: _____ Date: _____

<p>Which of the following best describes the risk's operations?</p> <p><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: _____</p> <p>How many guest rooms? _____</p> <p>How many floors does the building have? _____</p> <p>Who flips the mattresses? _____</p> <p>How are the mattresses turned? _____</p>	<p>Any Restaurant/Food Services? Yes <input type="checkbox"/> No <input type="checkbox"/> 24-hour room service? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>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:</p> <div style="border: 1px solid black; padding: 5px; min-height: 100px;"> <p>[text here]</p> </div>
<p>Do the employees have access to an elevator? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do the employees have the ability to store cleaning equipment on each floor? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Does the insured provide shuttle service? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please provide service hours: _____ <input type="checkbox"/> 24/7</p>

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 employees traveling: _____
Method of transportation: _____ Location(s): _____
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) Respiratory program: Yes No N/A
- 4) Driver safety training plan: Yes No N/A
- 5) Forklift training & safety plan: Yes No N/A
- If Yes – Annual Certification required:** Yes No N/A
- 6) MSDS available for all chemicals/products used: Yes No N/A
- 7) Written Lockout/Tag out/Block out Procedures: Yes No N/A
- 8) Hazardous chemicals safety plan: Yes No N/A
- 9) Confined spaces plan: Yes No N/A
- 10) Active safety incentive program for all employees: Yes No N/A
- 11) Are supervisors held accountable for a safe work environment? Yes No N/A
- 12) Is there a dedicated full time safety manager? Yes No N/A

If Yes – Please provide:

Name: _____ Title: _____

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

Year implemented: _____

[Text here]

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

[Text here]