

Restaurants - 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 insured's operations? (check all that apply)</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Banquet Hall</td> <td><input type="checkbox"/> Fine dining</td> </tr> <tr> <td><input type="checkbox"/> Fast Food</td> <td><input type="checkbox"/> Tavern/Sports Bar</td> </tr> <tr> <td><input type="checkbox"/> Casual Dining/Family Style</td> <td><input type="checkbox"/> Cafeteria/Bufferet</td> </tr> <tr> <td><input type="checkbox"/> Pizza Delivery</td> <td><input type="checkbox"/> Diner</td> </tr> <tr> <td><input type="checkbox"/> Hotel/Resort Restaurant</td> <td><input type="checkbox"/> Mobile Catering Truck</td> </tr> <tr> <td><input type="checkbox"/> Night Club</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p>Hours of operations: _____ am _____ pm <input type="checkbox"/> 24 hours</p>	<input type="checkbox"/> Banquet Hall	<input type="checkbox"/> Fine dining	<input type="checkbox"/> Fast Food	<input type="checkbox"/> Tavern/Sports Bar	<input type="checkbox"/> Casual Dining/Family Style	<input type="checkbox"/> Cafeteria/Bufferet	<input type="checkbox"/> Pizza Delivery	<input type="checkbox"/> Diner	<input type="checkbox"/> Hotel/Resort Restaurant	<input type="checkbox"/> Mobile Catering Truck	<input type="checkbox"/> Night Club	<input type="checkbox"/> Other: _____	<p>Any off-site catering for private events, including delivery/set-up? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes; please explain, include types of events and services provided:</p> <div style="border: 1px solid black; padding: 5px; min-height: 30px;">[text here]</div> <p>Percentage of: Takeout _____ % Catering: _____ % Delivery: _____ % = 100 %</p> <p>Delivery hours: _____ am _____ pm <input type="checkbox"/> 24 hours <input type="checkbox"/> N/A</p>
<input type="checkbox"/> Banquet Hall	<input type="checkbox"/> Fine dining												
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<input type="checkbox"/> Night Club	<input type="checkbox"/> Other: _____												
<p>Is there entertainment; i.e. shows, bands, etc.: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please provide a brief description:</p> <div style="border: 1px solid black; padding: 5px; min-height: 30px;">[text here]</div>	<p>Does the insured require non-slip shoes? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, is this the "Shoes for Crews" program? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Valet Parking Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, performed by: <input type="checkbox"/> Employees <input type="checkbox"/> Sub-contractor(s)</p> <p>If Sub-contracted out, are Certificates of Insurance collected? Yes <input type="checkbox"/> No <input type="checkbox"/></p>												
<p>Does the insured have security guards or bouncers? Yes <input type="checkbox"/> No <input type="checkbox"/></p>													

General Classification Evaluation:

- 1) 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: _____

- 2) Vehicle exposure: Yes No
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: _____

- 3) Any Out of State, International, or Overnight Travel: Yes No
If Yes - Please provide:
Number of employees traveling: _____ Location(s): _____
Method of transportation: _____ Frequency of travel: _____

- 4) 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) Active safety incentive program for all employees: Yes No N/A
- 6) Are supervisors held accountable for a safe work environment? Yes No N/A
- 7) Is there a dedicated full time safety manager? Yes No N/A

If Yes – Please provide:

Name: _____ Title: _____

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

Year implemented: _____

[Text here]

Machinery and Equipment:

- 1) Age of equipment in years: 0-5 5-10 10-20 20+
- 2) Condition of the equipment: Excellent Good Average Poor
- 3) Who is responsible for maintaining equipment? Insured Contractor Other: _____

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

[Text here]