Reset Form Print Form

Hotel / Motel - Industry Supplemental Questionnaire

Applicant Information:

Proposed Effective Date:	Legal Name:	Application ID:

Application completed by: Broker: ☐ Employer: ☐

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

Which of the following best describes the risk's operations?

☐ Hotel ☐ Hotel/Casino
☐ Motel ☐ Bed/Breakfast
☐ Timeshare – Brand name:
☐ Other:

How many guest rooms?

How many floors does the building have?

Who flips the mattresses?
How are the mattresses turned?

Any Restaurant/Food Services? Yes ☐ No ☐
24-hour room service? Yes ☐ No ☐

Is there a Bar, Lounge, or Night Club? Yes ☐ No ☐
Any entertainment provided? Yes ☐ No ☐ If yes, please explain:

Do the employees have access to an elevator? Yes ☐ No ☐

Do the employees have the ability to store cleaning equipment on each floor? Yes ☐ No ☐

Does the insured provide shuttle service? Yes ☐ No ☐

If yes, please provide service hours: ☐ 24/7

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: ____

Please explain...

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