

# 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</p> <p><input type="checkbox"/> Motel                      <input type="checkbox"/> Bed/Breakfast</p> <p><input type="checkbox"/> Timeshare – Brand name: _____</p> <p><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"/></p> <p>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"/></p> <p>Any entertainment provided? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain:</p> <div style="border: 1px solid black; height: 100px; margin-top: 5px;"> <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:

- 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.
- 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: \_\_\_\_\_
- 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: \_\_\_\_\_
- 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: \_\_\_\_\_
- CPR Training provided: Yes ☐ No ☐ If Yes - Number of Employees certified: \_\_\_\_\_

## Claims Handling:

- Is there a set procedure for reporting claims? Yes ☐ No ☐
- Is there a formal written accident investigation report? Yes ☐ No ☐
- 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 <input type="checkbox"/> Yes: Employer contribution: _____%	Percentage of employees enrolled: _____%
Retirement:	No <input type="checkbox"/> 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]