Hotel / Motel /Apt. Ops./ Build. Ops
Supplemental Application

Insured:_______________________ FEIN:_______________________ Eff. Date:_______________
Contact Name & Title:_______________________ Tel.#:_______________________ Fax.#:_______________________
Website Address:____

Years in business: _______________ #of Locations:_______________________
Description of operations:____
Union: ☐ Yes ☐ No If yes, name of Union:_______________________________
Current number of employees: Full time________ Part time________ Seasonal________ Volunteers________
Percent of employee turnover in the last 12 Months: Full time____________ Part time____________
Employee staffing expectation over the next 12 months: Full time____________ Part time____________
Average hourly wage in Governing Class: Full time $____________________ Part time $____________________
Average hourly wage in Clerical Class: Full time $____________________ Part time $____________________
Average hourly wage in Sales Class: Full time $____________________ Part time $____________________
Has the insured ever been in bankruptcy? ☐ Yes ☐ No
If yes, Explain____

Are ALL employees eligible Y/N; if no the who?_______________________________

		% paid by employer	% of participation
Group Health	☐ Yes ☐ No	________________	________________

Paid sick leave ☐ Yes ☐ No Vacation ☐ Yes ☐ No Retirement / Pension Plan ☐ Yes ☐ No
Name of Healthcare provider: ____
Do you use specific: Clinic_______________ Physician_____________ Emergency room ____________________
Full time nurse maintained on staff?: ☐ Yes ☐ No
CPR training provided?: ☐ Yes ☐ No

Safety program / IIPP compliant with SB 198 ☐ Yes ☐ No
Return to light duty plan ☐ Yes ☐ No
Return to full time modified work plan ☐ Yes ☐ No
Designated full time safety director ☐ Yes ☐ No Name:_______________________________
Safety meetings held for all employees ☐ Yes ☐ No Frequency of meetings:_______________________
Safety training for all employees ☐ Yes ☐ No Incentive program for employees ☐ Yes ☐ No
Personal protective safety equipment provided ☐ Yes ☐ No
Supervisors are held accountable for injuries/accidents ☐ Yes ☐ No
Accident investigation program in place ☐ Yes ☐ No

Employment application	☐ Yes ☐ No	Drug/substance abuse	☐ Yes ☐ No
Reference checks	☐ Yes ☐ No	Audiometric Testing	☐ Yes ☐ No
Motor Vehicle Record Check	☐ Yes ☐ No	Pre/Post employment physical	☐ Yes ☐ No
Volunteer labor used	☐ Yes ☐ No	Pathogenic test (i.e. lead)	☐ Yes ☐ No
Temporary labor used	☐ Yes ☐ No	Orthopedic back test	☐ Yes ☐ No

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Hours of operation: _________________to _______________ Number of daily shifts: ______________________________

Operation includes driving? ☐ Yes ☐ No Number of authorized drivers ___________ No. of vehicles__________

Types of vehicles driven____

Reason(s) for driving (delivery, sales calls, etc.)? ____

Frequency of driving: Daily ☐ Weekly ☐ Other ☐____

Driving radius: < 50 miles ☐ 51-100 miles ☐ 101-250 miles ☐ > 250 miles ☐

Frequency of MVY checks _________________________ Participation in CHP Pull program ☐ Yes ☐ No

Driver acceptability standards have been established ☐ Yes ☐ No

Vehicles inspection / maintenance program ☐ Yes ☐ No Frequency _________________________

Vehicle maintenance performed is performed by employees ☐ Yes ☐ No

Employees take vehicles home ☐ Yes ☐ No

Payroll		Premium	
Current Year	____________________	Current Year	____________________
1st Prior Year	____________________	1st Prior Year	____________________
2nd Prior Year	____________________	2nd Prior Year	____________________
3rd Prior Year	____________________	3rd Prior Year	____________________

Any travel out of state? ☐ Yes ☐ No No.# of employees who travel: ________________Frequency: ______________

Purpose:____

Is housing provided: ☐ Yes ☐ No If yes, # of employees housed and described their responsibilities:__________

____

Any furnished apartments available: ☐ Yes ☐ No If yes, % of units furnished? __________%

Are employees involved in property maintenance?: ☐ Yes ☐ No If yes, provide details: ______________________

Security Guards employed? ☐ Yes ☐ No Security cameras or other security devices on premises: ☐ Yes ☐ No

If yes, provide details (i.e armed or un armed, hours on premises):____

Does management collect payment from resident and/or is banking controlled by employees(s)? : ☐ Yes ☐ No

Are employees responsible for eviction notification and/or enforcement? ☐ Yes ☐ No

No. of guest rooms:________ Room rate: ☐ <$50 ☐ $50-100 ☐ $100+ Rent rooms: ☐ Daily ☐ Weekly ☐ Monthly

Any shuttle, limo or similar service?: ☐ Yes ☐ No If yes, please explain_______________________________________

Any restaurant exposures? ☐ Yes ☐ No Does it include 24 hour room service? ☐ Yes ☐ No Bar or Lounge area ☐ Yes ☐ No

Any entertainment provided? ☐ Yes ☐ No If yes, please explain ____

Housekeeping exposures: Moving of furniture? ☐ Yes ☐ No Mattress flipping or rotating? ☐ Yes ☐ No

If yes, how often and # of employees involved in process: ____

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Does insured work within 2 miles of the following building or facilities:

Government or Military base: ☐ Yes ☐ No
Financial Institutions including national/regional stock exchange ☐ Yes ☐ No
Sport Stadiums/ Arenas and Theme Parks ☐ Yes ☐ No
Major Bridges, Tunnels or Dams ☐ Yes ☐ No
Utilities or Power Generation Plants ☐ Yes ☐ No
Transportation Hubs, Railroads, Airports or Shipping ☐ Yes ☐ No
Historic/Symbolic buildings, monuments or parks ☐ Yes ☐ No

EXPOSURE INFORMATION – PREMISES – FIX LOCATION – EMPLOYEES

Total number of employee's: ___

State	Location #	Payroll	Total # of Employees	# of Shifts	Maximum # of Employees Per Shift	Type of Building (See List Below)	Year Built	# of Stories	Floors Occupied
		$							
		$							
		$							
		$							
		$							
		$							
		$							
		$							

If additional locations exist please include on a separate form.
Type of Building: (1.) Steel 3 stories or greater (2.) Frame 3 stories or less (3.) Concrete tilt up

1. Has the Insured previously participated in a Medical Provider Network? ☐ Yes ☐ No
2. Is the insured willing to participate in a Medical Provider Network? ☐ Yes ☐ No

Comments:
____
____
____

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND CERTIFIES THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE CERTIFIES THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

___________________________________ ____________________
SIGNATURE DATE