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Restaurants - 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 insured's operations?
(check all that apply)

- ☐ Banquet Hall
- ☐ Fast Food
- ☐ Casual Dining/Family Style
- ☐ Pizza Delivery
- ☐ Hotel/Resort Restaurant
- ☐ Night Club
- ☐ Fine dining
- ☐ Tavern/Sports Bar
- ☐ Cafeteria/Buffet
- ☐ Diner
- ☐ Mobile Catering Truck
- ☐ Other:

Hours of operations: ☐ am ☐ pm ☐ 24 hours

Any off-site catering for private events, including delivery/set-up?
Yes ☐ No ☐
If yes; please explain, include types of events and services provided:

Percentage of:
Takeout ☐ % Catering: ☐ % Delivery: ☐ % = **100 %**

Delivery hours: ☐ am ☐ pm ☐ 24 hours ☐ N/A

Is there entertainment; *i.e. shows, bands, etc.:* Yes ☐ No ☐
If yes, please provide a brief description:

Does the insured have security guards or bouncers? Yes ☐ No ☐

Does the insured require non-slip shoes? Yes ☐ No ☐
If yes, is this the "*Shoes for Crews*" program? Yes ☐ No ☐

Valet Parking Yes ☐ No ☐
If yes, performed by: ☐ Employees ☐ Sub-contractor(s)
If Sub-contracted out, are Certificates of Insurance collected? Yes ☐ No ☐

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:
   Method of transportation: Location(s):
   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: ____

Please explain...

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?