

## Restaurants - Industry Supplemental Questionnaire

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

### 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> <tr> <td>Banquet Hall</td> <td>Fine Dining</td> </tr> <tr> <td>Fast Food</td> <td>Tavern/Sports Bar</td> </tr> <tr> <td>Casual Dining/Family Style</td> <td>Cafeteria/Buffer</td> </tr> <tr> <td>Pizza Delivery</td> <td>Diner</td> </tr> <tr> <td>Hotel/Resort Restaurant</td> <td>Mobile Catering Truck</td> </tr> <tr> <td>Night Club</td> <td>Other:</td> </tr> </table> <p>Hours of operations: ____ am ____ pm 24 hours</p>	Banquet Hall	Fine Dining	Fast Food	Tavern/Sports Bar	Casual Dining/Family Style	Cafeteria/Buffer	Pizza Delivery	Diner	Hotel/Resort Restaurant	Mobile Catering Truck	Night Club	Other:	<p>Any off-site catering for private events, including delivery/set-up? Yes No <b>If yes</b>, please explain, include types of events and services provided:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>Percentage of: Takeout: ____ % Catering: ____ % Delivery: ____ % = <b>100 %</b></p> <p>Delivery hours: ____ am ____ pm 24 hours N/A</p>
Banquet Hall	Fine Dining												
Fast Food	Tavern/Sports Bar												
Casual Dining/Family Style	Cafeteria/Buffer												
Pizza Delivery	Diner												
Hotel/Resort Restaurant	Mobile Catering Truck												
Night Club	Other:												
<p>Is there entertainment, i.e. shows, bands, etc.: Yes No <b>If yes</b>, please provide a brief description:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<p>Does the insured require non-slip shoes? Yes No <b>If yes</b>, is this the "Shoes for Crews" program? Yes No</p> <p>Valet Parking: Yes No <b>If yes</b>, performed by: Employees Sub-contractor(s) If sub-contracted out, are Certificates of Insurance collected? Yes No</p>												
Does the insured have security guards or bouncers? Yes No													

### General Classification Evaluation:

- 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: 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  
MVRs 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 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) Do you maintain a written Workplace Violence Prevention Plan? Yes No N/A
- 4) Respiratory program: Yes No N/A
- 5) Driver safety training plan: Yes No N/A
- 6) Active safety incentive program for all employees: Yes No N/A
- 7) Are supervisors held accountable for a safe work environment? Yes No N/A
- 8) Is there a dedicated full-time safety manager? Yes No N/A

**If Yes – Please provide:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

- 9) Safety meetings are conducted: Daily Weekly Monthly Quarterly Does not conduct safety meetings
- Are safety meetings documented? Yes No
- 10) Personal Protective Equipment provide to all employees: No Yes, please list types: \_\_\_\_\_
- 11) Employee to Supervisor ratio: \_\_\_\_ / \_\_\_\_
- 12) 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?**