HOSPITALITY COVER PLUS+™

NATIONAL INSURANCE PROGRAM

DII DIVERSIFIED INSURANCE INDUSTRIES

YOUR GUIDE TO CLAIMS REPORTING
...SEEING YOU THROUGH

HOSPITALITY COVER PLUS+
PO BOX 1572 • COCKEYSVILLE, MD 21030
P (410) 319.0624 • F (410) 433.3440
WWW.HOSPITALITYCOVERPLUS.COM

DII DIVERSIFIED INSURANCE INDUSTRIES

Contents

Welcome

Your DII Claims Representatives:

We are pleased to present your Guide to Loss Reporting, designed with your risk management needs in mind. Please report all claims, or events you believe could become a claim, as you are made aware of them.

Your DII Claims Contact:

HCP Claims
410.319.0685
HCPClaims@dii-ins.com

Prompt reporting of losses enables your insurance company to offer you more prompt settlements. Rising claims costs continue to be a significant challenge facing employers. Your team can help reduce this cost by reporting claims promptly and thoroughly. In fact, the sooner a claim is reported, the lower the total cost of the claim is likely to be.

Slow reporting can increase claims costs by 50% or more.

Within 24 hours of reporting your loss, the carrier's loss adjuster should make contact with you. If you do not receive this call, please notify DII immediately.

Customer service is our priority. While we realize that experiencing a loss may not be pleasant, we can assist in minimizing the inconvenience to you and the guest. Thank you for allowing us the opportunity to serve you.

Very Cordially Yours,

Bob Barczak
Vice President, Risk Management Group

Automobile Claims

For automobile or truck related incidents, including your liability for bodily injury or property damage to others, their vehicles, or property, or claims involving physical damage to your property, gather as much of the following information as possible:

- Date and time of loss
- Location and description of accident
- Vehicles involved (year, make, model, VIN)
- Description of damage
- Photos of damage and scene, if possible
- Description of injuries, if any (complete a Workers' Compensation First Report of Injury if an employee is injured in the accident)
- Witness contact information
- Police department contact information and accident report number
- Estimated repair costs

Complete the Automobile Claims Form (Page 5)

Complete the Supervisor's Investigation Form (Page 16)

Do not discuss fault, do not admit liability, and do not voluntarily make payment for any claim. You may ask if the person involved would like medical treatment, but do not recommend treatment or offer to pay for the treatment.

The Automobile Claims Form must be completed by an employee of the property. **Claims Forms are never given to guests to complete or for a copy.**

Send completed forms to the DII Claims Department as soon as possible via:

- FAX: 410.433.3440
- EMAIL: HCPClaims@dii-ins.com

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Automobile Claims Form

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

YOUR INFORMATION	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
GENERAL MANAGER:	HOTEL PHONE:
GENERAL MANAGER CELL PHONE:	POLICE REPORT NUMBER:

YOUR VEHICLE INFORMATION	
VEHICLE (YEAR,MAKE,MODEL):	
VIN:	DRIVER:
DRIVER'S ADDRESS:	
DRIVER CELL PHONE:	DRIVER ALTERNATE PHONE:
DESCRIBE INCIDENT & DAMAGE:	
ACCIDENT LOCATION:	
WEATHER CONDITIONS:	

OTHER VEHICLE INFORMATION	
VEHICLE (YEAR, MAKE, MODEL):	
VEHICLE OWNER:	TAG NUMBER:
OWNER'S ADDRESS:	
OWNER CELL PHONE:	OWNER ALTERNATE PHONE:
INSURANCE COMPANY:	POLICY NUMBER:
DAMAGE TO VEHICLE:	

WITNESS INFORMATION	
NAME OF WITNESS:	
WITNESS PHONE:	WITNESS EMAIL ADDRESS:

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

REPORT COMPLETED BY:	PHONE:

Property Claims

For incidents involving damage to your property (including building, fixtures, and furniture), gather as much of the following information as possible:

- Date and time of loss
- Description of the occurrence
- Location and description of damage
- Photos of damage and scene, if possible
- Estimated repair costs

Take the following steps:

- Take the necessary steps to protect the property from further damage
- Call a restoration company or emergency cleanup service to mitigate your loss
- Document your expenses
- Compile any service or repair documents
- Keep all damaged property as is. The insurance company may want to inspect it
- Complete an inventory of damaged and destroyed property (a brief description of the item, estimated replacement cost, age of the item, and where it was purchased)
- File a police report for any theft

Complete the Property Claims Form (Page 7)

Complete the Supervisor's Investigation Form (Page 16)

The Property Claims Form must be completed by an employee of the property.
Claims Forms are never given to guests to complete or for a copy.

Send completed forms to the DII Claims Department as soon as possible via:

- FAX: 410.433.3440
- EMAIL: HCPClaims@dii-ins.com

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Property Claims Form

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

YOUR INFORMATION	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
HOTEL ADDRESS:	
GENERAL MANAGER:	HOTEL PHONE:
GENERAL MANAGER CELL PHONE:	POLICE REPORT NUMBER:
LOSS LOCATION:	ESTIMATED COST OF REPAIRS:
DESCRIBE INCIDENT:	

WITNESS INFORMATION	
NAME OF WITNESS:	
WITNESS PHONE:	WITNESS EMAIL ADDRESS:

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

REPORT COMPLETED BY:	PHONE:

General Liability Claims

For allegations of bodily injury or property damage from somebody other than an employee, and not related to an automobile accident, gather as much of the information below as possible. This includes guest injuries and alleged loss or damage of guest property.

- Date and time of loss
- Description of the occurrence
- Contact information for the parties involved
- Location and description of damage
- Photos of damage and scene, if possible
- Witness contact information
- File a police report for any alleged theft

If suit papers are received:

- Record the date and time suit papers were received and to whom they were served
- Verify the response date
- Forward the suit papers to DII immediately for review and handling

Complete the General Liability Claims Form (Page 9)

Complete the Supervisor's Investigation Form (Page 16)

Do not discuss fault, do not admit liability, and do not voluntarily make payment for any claim. You may ask if the person involved would like medical treatment, but do not recommend treatment or offer to pay for the treatment.

The General Liability Claims Form must be completed by an employee of the property. **Claims Forms are never given to guests to complete or for a copy.**

Send completed forms to the DII Claims Department as soon as possible via:

- FAX: 410.433.3440
- EMAIL: HCPClaims@dii-ins.com

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

General Liability Claims Form

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

YOUR INFORMATION	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
HOTEL ADDRESS:	
GENERAL MANAGER:	HOTEL PHONE:
GENERAL MANAGER CELL PHONE:	POLICE REPORT NUMBER:
LOSS LOCATION:	ESTIMATED COST OF REPAIRS:

INJURIES	
NAME OF INJURED PERSON:	
ADDRESS:	
CELL PHONE:	ALTERNATE PHONE:
DESCRIBE INCIDENT:	
DESCRIBE INJURY:	
WEATHER CONDITIONS:	
NAME OF INJURED PERSON:	
ADDRESS:	
CELL PHONE:	ALTERNATE PHONE:
DESCRIBE INCIDENT:	
DESCRIBE INJURY:	
ADDITIONAL INFORMATION (WERE THERE OTHERS INVOLVED? WAS THE GUEST CARRYING ANYTHING?):	

WITNESS INFORMATION	
NAME OF WITNESS:	
WITNESS PHONE:	WITNESS EMAIL ADDRESS:

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

REPORT COMPLETED BY:	PHONE:

Workers' Compensation Claims

For incidents involving employee bodily injury, or loss of pay for a work related injury in the course of employment:

Employer MUST complete the Workers' Compensation First Report of Injury Form (Page 11)

Complete the Supervisor's Investigation Form (Page 16)

Do not discuss fault, do not admit liability, and do not voluntarily make payment for any claim. You may ask if the person involved would like medical treatment, but do not recommend treatment or offer to pay for the treatment.

Send completed forms to the DII Claims Department as soon as possible via:

- FAX: 410.433.3440
- EMAIL: HCPClaims@dii-ins.com

Workers' Compensation Claims Form

ACORD® WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER / ADMINISTRATOR CLAIM NUMBER *	REPORT PURPOSE CODE *
	JURISDICTION * / JURISDICTION LOG NUMBER *	
	INSURED REPORT NUMBER / OSHA CASE NUMBER	
INDUSTRY CODE / EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #: / PHONE #

CARRIER / CLAIMS ADMINISTRATOR

CARRIER (NAME AND ADDRESS)	POLICY PERIOD TO / CHECK IF APPROPRIATE: ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME AND ADDRESS)
PHONE (A/C, No, Ext):		PHONE (A/C, No, Ext):
CARRIER FEIN *	POLICY / SELF-INSURED NUMBER	ADMINISTRATOR FEIN *
AGENT NAME:	AGENT CODE NUMBER:	

EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS: ☐ UNMARRIED/SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION / JOB TITLE	
E-MAIL ADDRESS:			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE *	
RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED / WEEK	FULL PAY FOR DAY OF INJURY? (Y / N) ☐ / DID SALARY CONTINUE? (Y / N) ☐	

OCCURRENCE / TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE ☐ CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME / PHONE (A/C, No, Ext):		TYPE OF INJURY / ILLNESS		PART OF BODY AFFECTED	
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? (Y / N) ☐		TYPE OF INJURY / ILLNESS CODE *		PART OF BODY AFFECTED CODE *	
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL				CAUSE OF INJURY CODE *	
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? (Y / N) ☐ / WERE THEY USED? (Y / N) ☐			
PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT: ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC / HOSP ☐ EMERGENCY CARE ☐ OVERNIGHT HOSPITALIZATION ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
WITNESS NAME: / PHONE (A/C, No, Ext):		WITNESS NAME: / PHONE (A/C, No, Ext):			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER	

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Workers' Compensation Claims Form

APPLICABLE IN ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

APPLICABLE IN ALASKA

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

APPLICABLE IN ARIZONA

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN ARKANSAS

Any person or entity who willfully and knowingly makes any material false statement or representation or who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme or artifice for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully decreasing any claim for benefit or payment or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium (or who aids and abets for either said purpose), under this chapter shall be guilty of a Class D. felony.

APPLICABLE IN CALIFORNIA

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

APPLICABLE IN COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN CONNECTICUT

This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

APPLICABLE IN DELAWARE AND OKLAHOMA

Any person who knowingly and with intent to injure, defraud, or deceive any Insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. The lack of such a statement shall not constitute a defense against prosecution under this section. *Delaware Statutes Regulations: Del #C Section 913(B)

APPLICABLE IN THE DISTRICT OF COLUMBIA

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA

Pursuant to S. 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in S. 775.082, S. 775.083, or S. 775.084, Florida Statutes.

APPLICABLE IN HAWAII

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

EMPLOYEE SIGNATURE: _____

Workers' Compensation Claims Form

APPLICABLE IN IDAHO

Any person who knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.

APPLICABLE IN INDIANA

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

APPLICABLE IN KANSAS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KENTUCKY, LOUISIANA, MAINE, MICHIGAN, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH DAKOTA, PENNSYLVANIA, RHODE ISLAND, SOUTH DAKOTA, VIRGINIA AND WEST VIRGINIA

Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and [NY: substantial] civil penalties. In LA, ME and VA, insurance benefits may also be denied.

APPLICABLE IN MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MINNESOTA

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEVADA

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

APPLICABLE IN NEW HAMPSHIRE

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

APPLICABLE IN OHIO

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICABLE IN TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

APPLICABLE IN TEXAS

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN UTAH

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

EMPLOYEE SIGNATURE: _____

Workers' Compensation Claims Form

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN FIELDS MARKED *

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System published by the Federal Office of Management and Budget.

OSHA CASE NUMBER:

Transfer the case number from the OSHA 300 log after you record the case there.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION / JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise deigned by statute.

CONTACT NAME / PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY / ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

Workers' Compensation Claims Form

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness / abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following the most recent disability period on which the employee returned to work.

DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Supervisor's Investigation Form

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

TO BE COMPLETED BY SUPERVISOR FOR ALL INCIDENTS	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
GENERAL MANAGER:	HOTEL PHONE:
WHEN AND HOW WERE YOU FIRST INFORMED OF THE INCIDENT?	
DESCRIBE YOUR ACCOUNT OF HOW THE INCIDENT OCCURRED (WAS THE GUEST CARRYING ANYTHING? WERE THERE OTHERS INVOLVED? DID THE GUEST HAVE A CANE? ETC.)	
DID THE INCIDENT RESULT FROM AN EMPLOYEE NOT FOLLOWING SAFETY RULES?	
HAVE THERE BEEN OTHER VIOLATIONS OF THIS TYPE?	
EXPLAIN:	
DID THIS INCIDENT INVOLVE A THIRD PARTY (VISITOR, GUEST, VENDOR)?	
EXPLAIN:	
HOW COULD THIS INCIDENT HAVE BEEN PREVENTED?	
WHAT WILL THE SUPERVISOR DO TO PREVENT THIS FROM OCCURRING AGAIN?	
ADDITIONAL INFORMATION:	

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

REPORT COMPLETED BY:	PHONE:

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Valet Claims Form

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

YOUR INFORMATION	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
GENERAL MANAGER:	MANAGER ON DUTY:
HOTEL PHONE:	POLICE REPORT NUMBER:
VALET WHO PARKED VEHICLE:	VALET WHO RETRIEVED VEHICLE:
CELL PHONE:	CELL PHONE:
DRIVER LICENSE NUMBER:	DRIVER LICENSE NUMBER:
INCIDENT INFORMATION	
VEHICLE (YEAR,MAKE,MODEL):	
VIN:	TIME OF INCIDENT:
APPROXIMATE TEMPERATURE:	DRIVER AT TIME OF INCIDENT:
WEATHER CONDITIONS:	
DESCRIBE INCIDENT & DAMAGE:	
ACCIDENT LOCATION:	
GUEST INFORMATION	
VEHICLE OWNER:	OWNER CELL PHONE:
OWNER'S ADDRESS:	
WITNESS INFORMATION	
NAME OF WITNESS:	
WITNESS PHONE:	WITNESS EMAIL ADDRESS:
CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.	
REPORT COMPLETED BY:	PHONE:
ALL VALET CLAIMS MUST INCLUDE PHOTOS & COPY OF VALET TICKET	

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Valet Investigation Form

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

MUST BE COMPLETED BY VALET FOR ALL INCIDENTS	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
GENERAL MANAGER:	MANGER ON DUTY:
DESCRIBE YOUR ACCOUNT OF HOW THE INCIDENT OCCURRED:	
DID THE INCIDENT RESULT FROM AN EMPLOYEE NOT FOLLOWING SAFETY RULES?	
IF "YES," EXPLAIN:	
HAVE THERE BEEN OTHER INCIDENTS OF THIS TYPE?	
IF "YES," EXPLAIN:	
HAVE YOU BEEN INVOLVED IN ANY OTHER VEHICLE INCIDENTS?	
IF "YES," EXPLAIN:	
HOW COULD THIS INCIDENT HAVE BEEN PREVENTED?	
ADDITIONAL INFORMATION:	

CLAIM FORM MUST BE COMPLETED BY A HOTEL EMPLOYEE.. CLAIM FORM IS FOR INTERNAL USE ONLY & NOT PROVIDED TO A GUEST.

REPORT COMPLETED BY:	PHONE:

Additional Notes