AUTOMOBILE CLAIMS FORM

Your Information	
Today's Date:	Date of Loss:
Name of Insured: Hospitality Cover Plus, LLC	
Hotel Name:	
Address:	
Cell Phone:	Alternative Phone:
Policy Number:	Police Report Number:
Your Vehicle Information	
Vehicle (Year, Make, Model):	
VIN Number:	Driver's Name:
Driver's Address:	
Cell Phone:	Alternative Phone:
Describe Incident & Damage to Vehicle:	
Accident Location:	
Other Vehicle Involved	
Vehicle (Year, Make, Model):	
Owner of Vehicle:	Tag Number:
Owner's Address:	
Cell Phone:	Alternative Phone:
Insurance Company:	Policy Number:
Address:	
Describe Incident & Damage to Vehicle:	
Witness Information	
Name of Witness #1:	
Address:	
Cell Phone:	Alternative Phone:
Name of Witness #2:	
Address:	
Cell Phone:	Alternative Phone:
Additional Information:	
Completed By::	Phone:

© DIVERSIFIED INSURANCE INDUSTRIES, INC.

PROPERTY CLAIMS FORM

Loss Information – A Police Report is REQUIRED for all Theft Losses	
Today's Date:	Date of Loss:
Name of Insured: Hospitality Cover Plus, LLC	
Hotel Name:	
Address:	
Cell Phone:	Alternate Phone:
Loss Location:	
Estimated Cost of Repairs:	
Describe Accident:	
Witness Information	
Name of Witness:	
Address:	
Cell Phone:	Alternate Phone:
Name of Witness:	
Address:	
Cell Phone:	Alternate Phone:
Additional Information:	
Report Completed By:	Phone:

By fully completing the Property Claims Form and submitting it to your insurance carrier, with a copy to DII, you expedite the processing of your claim.

© DIVERSIFIED INSURANCE INDUSTRIES, INC.

GENERAL LIABILITY CLAIMS FORM

Loss Information – A Police Report is REQUIRED for all Theft Losses	
Today's Date:	Date of Loss:
Name of Insured: Hospitality Cover Plus, LLC	
Hotel Name:	
Address:	
Cell Phone:	Alternate Phone:
Loss Location:	
Estimated Cost of Repairs:	
Describe Accident:	
Injuries	
Name of Person Injured #1:	
Address:	
Cell Phone:	Alternate Phone:
Describe Injury:	
Name of Person Injured #2:	
Address:	
Cell Phone:	Alternate Phone:
Describe Injury:	
Witness Information	
Name of Witness #1:	
Address:	
Cell Phone:	Alternate Phone:
Name of Witness #2:	
Address:	
Cell Phone:	Alternate Phone:
Additional Information:	
Report Completed By:	Phone:

By fully completing the General Liability Claims Form and submitting it to your insurance carrier, with a copy to DII, you expedite the processing of your claim.

© DIVERSIFIED INSURANCE INDUSTRIES, INC.

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

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

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)	POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	CHECK IF APPROPRIATE ☐ SELF INSURANCE	
CARRIER FEIN *	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN *
AGENT NAME & 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 EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE *	
RATE PER: ☐ DAY ☐ MONTH ☐ WEEK ☐ OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO	

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	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? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

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
WITNESSES (NAME & PHONE #)		

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

© 1993-2008 ACORD CORPORATION. All rights reserved.
REPRINTED WITH PERMISSION OF IAIABC
The ACORD name and logo are registered marks of ACORD