DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Automobile Claims Form

YOUR INFORMATION	
TODAYS 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 ADDRESS:
REPORT COMPLETED BY:	PHONE:

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Property Claims Form

YOUR INFORMATION	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
HOTEL ADRESS:	
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 ADDRESS:
REPORT COMPLETED BY:	PHONE:

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

General Liability Claims Form

YOUR INFORMATION	
TODAY'S DATE:	DATE OF LOSS:
NAME OF INSURED: HOSPITALITY COVER PLUS+	
HOTEL NAME:	
HOTEL ADRESS:	
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 ANYTTHING?	
WITNES INFORMATION	
NAME OF WITNESS:	
WITNESS PHONE:	WITNESS ADRESS:
REPORT COMPLETED BY:	PHONE:

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Supervisor's Investigation Report

TO BE COMPLETED BY SUPERVISOR FOR ALL INCIDENTS	
TODAYS 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 SAFTER 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 SPERVISOR DO TO PREVENT THIS FROM OCCURING AGAIN?	
ADDITIONAL INFORMATION:	
REPORT COMPLETED BY:	PHONE:

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	
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #: / PHONE #
INDUSTRY CODE / EMPLOYER FEIN		

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

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Valet Claims Form

YOUR INFORMATION	
TODAYS 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 RETRIVED 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 ADDRESS:
REPORT COMPLETED BY:	PHONE:
ALL VALET CLAIMS MUST INCLUDE PHOTOS & COPY OF VALET TICKET	

DII DIVERSIFIED INSURANCE INDUSTRIES

HOSPITALITY COVER PLUS+™

Valet Investigation Form

MUST BE COMPLETED BY VALET FOR ALL INCIDENTS	
TODAYS 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 NOT FOLLOWING SAFTEY 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:	

REPORT COMPLETED BY:	PHONE: