

Automobile Claims Form

YOUR INFORMATION

TODAYS DATE:

DATE OF LOSS:

NAME OF INSURED: MARSHALL HOTELS & RESORTS

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:

Property Claims Form

YOUR INFORMATION

TODAY'S DATE:

DATE OF LOSS:

NAME OF INSURED: MARSHALL HOTELS & RESORTS

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 ADDRESS:

REPORT COMPLETED BY:

PHONE:

General Liability Claims Form

YOUR INFORMATION

TODAY'S DATE:

DATE OF LOSS:

NAME OF INSURED: MARSHALL HOTELS & RESORTS

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?)

WITNES INFORMATION

NAME OF WITNESS:

WITNESS PHONE:

WITNESS ADDRESS:

REPORT COMPLETED BY:

PHONE:

Supervisor's Investigation Report

TO BE COMPLETED BY SUPERVISOR FOR ALL INCIDENTS

TODAYS DATE:

DATE OF LOSS:

NAME OF INSURED: MARSHALL HOTELS & RESORTS

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 SUPERVISOR DO TO PREVENT THIS FROM OCCURING AGAIN?

ADDITIONAL INFORMATION:

REPORT COMPLETED BY:

PHONE:



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 #:
INDUSTRY CODE	EMPLOYER FEIN			PHONE #	

CARRIER / CLAIMS ADMINISTRATOR

CARRIER (NAME AND ADDRESS)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME AND ADDRESS)	
PHONE (A/C, No, Ext):		CHECK IF APPROPRIATE	PHONE (A/C, No, Ext):	
CARRIER FEIN *	POLICY / SELF-INSURED NUMBER	SELF INSURANCE	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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION / JOB TITLE	
E-MAIL ADDRESS:		# OF DEPENDENTS	EMPLOYMENT STATUS		
PHONE		NCCI CLASS CODE *			
RATE	PER:	DAY	MONTH	AVERAGE WEEKLY WAGES	# DAYS WORKED / WEEK
	WEEK		OTHER:		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		TYPE OF INJURY / ILLNESS			PART OF BODY AFFECTED		
PHONE (A/C, No, Ext):		TYPE OF INJURY / ILLNESS CODE *			PART OF BODY AFFECTED CODE *		
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? (Y / N) <input type="checkbox"/>							
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	
						<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC / HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> OVERNIGHT HOSPITALIZATION <input type="checkbox"/> FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED	
WITNESS NAME:			WITNESS NAME:				
PHONE (A/C, No, Ext):			PHONE (A/C, No, Ext):				
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME	TITLE	PHONE NUMBER			

Valet Claims Form

YOUR INFORMATION

TODAYS DATE:	DATE OF LOSS:
NAME OF INSURED: MARSHALL HOTELS & RESORTS	
HOTEL NAME:	
GENERAL MANAGER:	MANAGER ON DUTY:
HOTEL PHONE:	POLICE REPORT NUMBER:
VALET WHO PARKED VEHICLE:	VALET WHO RETRIVED VEHICLE:
CELL PHONE:	CELL PHONE:
DRIVERS LICENSE NUMBER:	DRIVERS 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

Valet Investigation Form

MUST BE COMPLETED BY VALET FOR ALL INCIDENTS

TODAYS DATE:

DATE OF LOSS:

NAME OF INSURED: MARSHALL HOTELS & RESORTS

HOTEL NAME:

GENERAL MANAGER:

MANGER ON DUTY:

DESCRIBE YOUR ACCOUNT OF HOW THE INCIDENT OCCURRED:

DID THE INCIDENT RESULT FROM 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:

REPORT COMPLETED BY:

PHONE: