Submit Form

Producer:_____Effective Date:_____Need By Date:_____

Name of Insured:_____Contact Person:_____

DBA:_____Years in Business:_____Experience:_____

Type of Company: Non Profit

FEIN #:_____SS #:_____

Mailing Address: _____

_____

Phone #:_____Fax #: _____

Email:_____Web Page:_____

Location #1

_____ Coins %:_____

_____ Sq. Ft: _____

_____ *Year Built:_____

Type of Construction:_____County:_____

Sprinkled: No Alarmed: No City Limits: No

*Updates if over 25 years old: Plumbing_____Heat_____Roof_____Wiring_____

Building Value $:_____Deductible:_____

Soft/Hard

Contents $:_____EDP $: _____Property of Others:_____

Business Income(Monthly Indemnity or Coins):_____

Improvements or Betterments:_____

Location #2

_____ Coins %:_____

_____ Sq. Ft: _____

_____ *Year Built:_____

Type of Construction:_____ County:_____

Sprinkled: No Alarmed: No City Limits: No

*Updates if over 25 years old: Plumbing_____ Heat_____ Roof_____ Wiring_____

Building Value $:_____ Deductible:_____

Soft/Hard

Contents $:_____ EDP $: _____ Property of Others:_____

Business Income(Monthly Indemnity or Coins):_____

Improvements or Betterments:_____

Nature of Business:_____

_____

_____

_____

General Liability

Limits:

General Aggregate:_____ Products & Completed Ops:_____

Personal & Advertising:_____ Each Occurrence:_____

Damage to Rented Prem:_____ Medical Expense:_____

Employee Benefits:_____

Loc #	Class	Pr. Basis	Exposure	Rate

Auto's owned by the business :_____

Year	Make	Model	Vin#	Cost New	Comp Ded	Coll Ded

Hired Non-Owned Auto:_____

Hired Car Physical Damage_____

Motor Truck Cargo $:_____

Driver's List

Name	D.O.B.	DL #	State

Automobile Coverage:

Liability:_____

PIP:_____

Medical:_____

UM:_____

Inland Marine

Unscheduled Tools and Equipment Total Value $:_____

Scheduled Tools and Equipment Total Value $:_____

PLEASE ATTACH A LIST OF EQUIPMENT AND VAUES

Contactors Mobile Equipment

Year	Make	Model	Serial #	Value

Installation Floater $:_____

Work Comp

Mod Number:_____Which States: _____

Do the officers want to be included in the work comp? No

Are there any subs that do not have insurance? No

Code #	Class	Payroll	Rate	Premium	# Empl FT/PT

Owners:_____DOB:_____SS#:_____Owns%:_____

Owners:_____DOB:_____SS#:_____Owns%:_____

Owners:_____DOB:_____SS#:_____Owns%:_____

Umbrella

Amount of Umbrella $:_____

Retained Limit $:_____

Loss History

Property:

Date	Description	Amount

GL:

Date	Description	Amount

Auto:

Date	Description	Amount

WC:

Date	Description	Amount

	Current Carrier	Expiring Premium
Property		
GL		
Auto		
WC		
Umbrella		
IM		

Optional Coverage

Signs:

Description:_____ Value:_____ Ded:_____

Description:_____ Value:_____ Ded:_____

Glass:

Measurements:_____

Account Rec/Val Papers:

Limits:_____

Money & Securities:

Limit In/Out : _____ Deductible:_____

Employee Dishonesty:

Limit:_____ Deductible:_____