



SUBMIT

Request for Insurance Quotation

- Complete Business Information, plus any sections for which you are seeking a quote.
- Ignore sections for which you do not want coverage quoted.
- Return by fax or email. Contact information is below.

Business Information	
Name: _____	<input type="checkbox"/> Corp <input type="checkbox"/> LLC <input type="checkbox"/> Sole Prop
Mailing Address: _____	FEIN or SSN: _____
City, State, Zip: _____	Year Started: _____
Phone: _____	Current Insurance Company(s): _____
Fax: _____	Expiration Date(s): _____
Email: _____	Total Yearly Premium(s): _____
Inspection Point of Contact: _____	_____
Accounting Point of Contact: _____	_____
Street Address	
Location #1	_____
Location #2	_____
Location #3	_____
What does your business do? Describe all operations:	

Additional Named Insureds: _____	
Attach Separately	
<input type="checkbox"/> 5 Year, currently valued Loss Runs. (Ask your existing insurance agent/company for these and they should have them to you within 24 hours. If in business less than five years, send what you have. If no prior insurance, ignore.)	
Explain any losses over \$5,000	



Property <input type="checkbox"/> Do Not Quote Attach as many sheets as necessary	
Location #: _____ Building #: _____ Insurance Values Building: \$ _____ Contents: \$ _____ Business Income: \$ _____ Miscellaneous: \$ _____ Responding Fire Co: _____ Distance to Hydrant: _____ Year Built: _____ Sq Ft: _____ Year Updated: _____ Roof _____ Wiring _____ Plumbing _____ Heating _____	Alarms: <input type="checkbox"/> Fire <input type="checkbox"/> Burglar <input type="checkbox"/> Both <input type="checkbox"/> Local Only <input type="checkbox"/> Central Station Heat: <input type="checkbox"/> Oil <input type="checkbox"/> Electric <input type="checkbox"/> Other _____ Sprinklers? _____ Construction: (frame, masonry, etc.) _____ Roof: (metal, composition shingle, etc.) _____ Siding: (metal, vinyl, wood, etc.) _____
Location #: _____ Building #: _____ Insurance Values Building: \$ _____ Contents: \$ _____ Business Income: \$ _____ Miscellaneous: \$ _____ Responding Fire Co: _____ Distance to Hydrant: _____ Year Built: _____ Sq Ft: _____ Year Updated: _____ Roof _____ Wiring _____ Plumbing _____ Heating _____	Alarms: <input type="checkbox"/> Fire <input type="checkbox"/> Burglar <input type="checkbox"/> Both <input type="checkbox"/> Local Only <input type="checkbox"/> Central Station Heat: <input type="checkbox"/> Oil <input type="checkbox"/> Electric <input type="checkbox"/> Other _____ Sprinklers? _____ Construction: (frame, masonry, etc.) _____ Roof: (metal, composition shingle, etc.) _____ Siding: (metal, vinyl, wood, etc.) _____
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General Liability Do Not Quote

Limits

Per Occurrence \$1,000,000 \$2,000,000 Other: \$ _____
Aggregate \$1,000,000 \$2,000,000 \$3,000,000 Other: \$ _____

Location #1: Yearly Est. Gross Sales: \$ _____ Yearly Payroll: \$ _____

Location #2: Yearly Est. Gross Sales: \$ _____ Yearly Payroll: \$ _____

Location #3: Yearly Est. Gross Sales: \$ _____ Yearly Payroll: \$ _____

Do you currently offer health insurance to your employees? _____

Business Auto Do Not Quote

Coverage Limits

Liability \$500,000 \$1,000,000 \$1,500,000 Other: \$ _____
Uninsured Motorists (UM): \$500,000 \$1,000,000 \$1,500,000 Other: \$ _____
Underinsured Motorists (UIM) \$500,000 \$1,000,000 \$1,500,000 Other: \$ _____
Medical \$2,000 \$5,000 \$10,000 Other: \$ _____
PIP (if available in your state) \$2,000 \$5,000 \$10,000 Other: \$ _____
Physical Damage Deductible: \$500 \$1,000 \$2,500 Other: \$ _____

Garaging address (if different than mailing): _____

Cities where you operate: _____ Radius in Miles: _____

Any other vehicles owned but not listed? Yes No

Complete and Attach separately:

- Driver List (example below)
- Vehicle List (example below)

Internal Use Only:
 1 Any Auto 2 All Owned Autos 7 Listed Autos 8 Hired Autos 9 Non-owned Autos



Vehicle List

Attach only if quoting **Business Auto**. Use this form or attach a copy from your existing policy.

	Year	Make	Model	VIN	Total \$ Value	Seating Capacity*	Liab	Comp	Coll	Med	PIP
1							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Include driver in seating capacity.

Liab = Liability Comp = Comprehensive Coll = Collision Med = Medical Payments PIP = Personal Injury Protection
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Driver List

Attach only if quoting **Business Auto**. Use this form or attach a copy from your existing policy.

	Name	Date of Birth	License #	State Licensed:	Years Experience	# of Traffic Violations*
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

* Attach MVRs from your file



Workers' Compensation Do Not Quote

Coverage Limits

- \$100,000/\$500,000/\$100,000
- \$500,000/\$500,000/\$500,000
- \$1,000,000/\$1,000,000/\$1,000,000

Include with this application

- Current experience modification worksheet. Only applicable for businesses in operation four years or more. If your state is an NCCI state, obtain yours for free by calling them directly at 800.622.4123.

All payroll estimates yearly

Owners / Officer Payroll

Complete for any owner / officer with over 5% ownership interest.

Name	Date of Birth	Ownership %	Include/Exclude?	Payroll Estimate
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

Staff Payroll by Classification

Location No.	What do your employees do?	Approx No. of EE's	Annual Payroll Estimate	Internal Use. Class Code
1	Example 1: Drive forklift. Move wood in lumber yard.	4	\$100,000	
1	Example 2: Office / Clerical	2	\$50,000	



I would like to hear more about:			
Commercial Insurance Coverages	<u>Yes</u>	<u>No</u>	Personal Insurance Coverages
Umbrella Liability	<input type="checkbox"/>	<input type="checkbox"/>	
Cyber Liability/Data Breach	<input type="checkbox"/>	<input type="checkbox"/>	<u>Yes</u> <u>No</u>
Business Income With Extra Expense	<input type="checkbox"/>	<input type="checkbox"/>	High Net Worth Home
Inland Marine	<input type="checkbox"/>	<input type="checkbox"/>	Home
Flood	<input type="checkbox"/>	<input type="checkbox"/>	Flood
Boat/Protection & Indemnity/Jones Act	<input type="checkbox"/>	<input type="checkbox"/>	Excess Flood
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Auto
Ocean Marine	<input type="checkbox"/>	<input type="checkbox"/>	Valuables/Fine Arts
Employee Dishonesty	<input type="checkbox"/>	<input type="checkbox"/>	Personal Umbrella
Employment Practices Liability	<input type="checkbox"/>	<input type="checkbox"/>	Workers Comp <small>(Domestic Worker)</small>
Directors and Officers	<input type="checkbox"/>	<input type="checkbox"/>	Aviation
Employee Benefits Liability	<input type="checkbox"/>	<input type="checkbox"/>	Yacht
Fiduciary Liability	<input type="checkbox"/>	<input type="checkbox"/>	Director & Officers
Health – Group or individual	<input type="checkbox"/>	<input type="checkbox"/>	Wealth Protection
Life – Group or individual	<input type="checkbox"/>	<input type="checkbox"/>	Wealth Development
Disability – Group or individual	<input type="checkbox"/>	<input type="checkbox"/>	
Long Term Care – Group or individual	<input type="checkbox"/>	<input type="checkbox"/>	

Other Comments/Questions/Information:

Applicant Signature: _____ Date: _____

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