



Commercial Lines

Named Insured: _____ Email: _____

Address: _____ Phone #: _____

Website: _____ Effective Date: _____

City, County, State, and Zip: _____

Year Business Started: _____ FEIN #: _____ Years' Experience: _____

Business Type: Individual _____ Partnership _____ Corp _____ Not for Profit _____ Limited Liability Company _____

Other _____ If Other Please State: _____

Business/Operation Description: _____

Prior Carrier _____ Expiration Date _____

Reason for Leaving _____

Current Carrier: _____ Any Losses? Yes _____ No _____

If Yes, Describe: _____

BUSINESS AUTOMOBILE

Driver Information:

	Driver #1	Driver #2	Driver #3	Driver #4
Name				
DOB				
SS #				
DLN				
Years Licensed				
Occupation				
Accidents in the last 3 years (Y/N) (If Yes Please Describe)	Y/N	Y/N	Y/N	Y/N



BUSINESS QUESTIONNAIRE

Vehicle Information:

	VEH #1	VEH #2	VEH #3	VEH #4
Year				
Make				
Model				
Drivers Name				
DOB				
DLN				
VIN # (17 Characters)				
Annual Miles				
GVW				
Belts				
Bags				
ABS				
Accidents in the last 3 years (Y/N) (If Yes Please Describe)	Y / N	Y / N	Y / N	Y / N
PLPD (Y/N)	Y / N	Y / N	Y / N	Y / N

Additional Driver Information:

Accidents & Violations _____

Suspensions, DWI, or Reckless Driving? _____

Impairments _____

Requested Coverages:

BI _____

L/P _____

PD _____

T&L _____

MED _____

RENT _____

UM/UIM _____ PD _____

COMP _____

A/I _____

COLL _____



BUSINESS QUESTIONNAIRE

General Liability

Limits Requesting: _____

Class Code(s)	Descriptions	Rating Basis (Sales, Payroll, Area, Units, Etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of Full-Time Employees: _____ Part-Time: _____

Subcontractor Used? Yes _____ No _____

If Yes, Cost of Subcontracted Work: _____

Describe Work Performed by Subcontractor: _____

Is there a Subcontractor Agreement in Place? Yes _____ No _____

Are Certificates of Insurance Obtained from all Subcontractors? Yes _____ No _____

Inland Marine

Any *individual items with values more than \$1,000? Yes _____ No _____

Total value: \$ _____

*Descriptions of each item with serial numbers and values will be required to be attached to form

Any items with values less than \$1,000? Yes _____ No _____ Total Value: \$ _____

Deductible: \$1,000 _____ \$1,500 _____ \$2,000 _____ \$5,000 _____ Other _____

Property

Building: _____ Contents: _____ Business Income: _____

Construction: _____ Year Built: _____ Square Feet: _____

Alarms: _____ Burglar: _____ Fire: _____ Sprinkler: _____



BUSINESS QUESTIONNAIRE

Deductible: _____ FEIN _____

Building Updates (Years): _____

Roof: _____ Plumbing: _____ Heating: _____ Electric: _____

Workers Comp

FEIN: _____

Limits Requested: _____

State(s) of Business: _____

Number of Full-Time Employees: _____ Part-Time: _____

Class Code(s)	Description	Payroll
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Individual, Partner, or Limited Liability officers electing coverage? Yes _____ No _____

If Yes, Who? _____

Name	DOB	% of Ownership	Payroll
_____	_____	_____	_____

Today's Date: _____

Date to Producer/CSR: _____

Referred by: _____