

**APPLICANT'S INSTRUCTIONS:**

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.  
 (PLEASE TYPE OR PRINT IN INK)

**1. APPLICANT INFORMATION**

- a. Full name of applicant: \_\_\_\_\_
- b. Phone: ( ) \_\_\_\_\_
- c. Principal business address: \_\_\_\_\_
- d. Number of Employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Total \_\_\_\_\_
- d.  Individual  Partnership  Joint Venture  Corporation  Other (specify below) \_\_\_\_\_
- e. Desired effective date: \_\_\_\_\_
- f. Desired Limit: \$ \_\_\_\_\_ Desired Deductible: \$ \_\_\_\_\_
- g. Type of Coverage Desired:  Claims Made  Occurrence

**2. APPLICANT FACILITIES**

a. Please complete the following for each of your facilities:

	<u>Location Number</u>	<u>Name and Location Address</u>	<u>Description of Type of Facility</u>	<u>Parking Lot or Garage Maintained by Insured?</u>	<u>Adjacent Exposure?</u>	<u>Square Footage</u>
(i)	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
	_____	_____	_____			_____
	_____	_____	_____			_____
(ii)	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
	_____	_____	_____			_____
	_____	_____	_____			_____

b. Please complete the following for each location:

- (i) Year built \_\_\_\_\_
- (ii) Year Remodeled \_\_\_\_\_
- (iii) Number of Stories \_\_\_\_\_
- (iv) Construction: Frame, Brick, Concrete \_\_\_\_\_
- (v) Percentage of Building Occupied by Insured \_\_\_\_\_
- (vi) Other Occupancy \_\_\_\_\_
- (vii) Location Number \_\_\_\_\_

**2. APPLICANT FACILITIES (CONTD.)**

c. Is the Building Equipped with:

- |  |                       |
|--|-----------------------|
| (i) Complete Sprinkler System?                                       | (i) [ ] Yes [ ] No    |
| (ii) At Least Two Clearly Marked Exits at Each Floor?                | (ii) [ ] Yes [ ] No   |
| (iii) Self-Closing Fire Doors on Each Floor?                         | (iii) [ ] Yes [ ] No  |
| (iv) Automatic Fire Alarm System Connected to Local Fire Department? | (iv) [ ] Yes [ ] No   |
| (v) Smoke Detectors?   | (v) [ ] Yes [ ] No    |
| (vi) Emergency Electrical System?                                    | (vi) [ ] Yes [ ] No   |
| (vii) Heat Sensors?  | (vii) [ ] Yes [ ] No  |
| (viii) Fire Escape(s)?   | (viii) [ ] Yes [ ] No |
| (ix) Posted Emergency Evacuation Procedures?                         | (ix) [ ] Yes [ ] No   |
| (x) Properly Maintained Fire Extinguishers?                          | (x) [ ] Yes [ ] No    |

**3. BUSINESS INFORMATION**

a. How many years have you been in business?

b. Number of full-time staff: \_\_\_\_\_  
Part-Time: \_\_\_\_\_

c. Nature of your business:

d. What is your gross sales estimate? \$ \_\_\_\_\_  
What is your total payroll? \$ \_\_\_\_\_

e. How many units sold? \_\_\_\_\_  
How many clients? \_\_\_\_\_

f. Year 2000 Problem:

- (i) Do your computer systems store a four-digit year? [ ] Yes [ ] No
- (ii) If NO, please attach a description of corrective measures taken to resolve the systems problem presented by the year 2,000, including the date upon which you anticipate the problem will be solved.
- (iii) Are you, in the course of your business, involved in working to solve the year 2,000 problem as a consultant/advisor or as part of your employment? [ ] Yes [ ] No
- (iv) If YES, what percentage of your work is involved? \_\_\_\_%

**4. APPLICANT OPERATIONS**

a. Are you a subsidiary of another entity or do you have any subsidiaries? [ ] Yes [ ] No

b. Is a formal written safety program in place? [ ] Yes [ ] No  
(If Yes, please attach a copy of the safety program.)

c. Are written procedures in effect for incident reporting? [ ] Yes [ ] No

d. Any exposure to flammables, explosive, chemicals? [ ] Yes [ ] No

e. Any catastrophe exposure? [ ] Yes [ ] No

f. Any medical facilities provided or doctors employed/contracted? [ ] Yes [ ] No

g. Any exposure to radioactive materials? [ ] Yes [ ] No

h. Do operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? [ ] Yes [ ] No

i. Any operations sold, acquired, or discontinued in last five years? [ ] Yes [ ] No

j. Machinery or equipment loaned or rented to others? [ ] Yes [ ] No

**4. APPLICANT OPERATIONS (CONTD.)**

k. Are there any elevators or escalators owned by you?  Yes  No

If Yes, please indicate model and if the elevator and/or escalator is serviced by you under a maintenance contract.

n. Recreation facilities provided?  Yes  No

l. Any watercraft, docks, or floats owned, hired or leased?  Yes  No

o. Is there a swimming pool on the premises?  Yes  No

m. Any parking facilities owned/rented?  Yes  No

p. Sporting or social events sponsored?  Yes  No

**5. CONTRACTORS INFORMATION**

a. Do you draw plans, designs or specifications?  Yes  No

d. Do subcontractors carry coverages or limits less than yours?  Yes  No

b. Do any operations include blasting or do you utilize or store explosive material?  Yes  No

e. Are certificates of insurance required from subcontractors?  Yes  No

c. Do any operations include excavation, tunneling, underground work or earth moving?  Yes  No

f. Do you lease equipment to others with or without operators?  Yes  No

**6. APPLICANT HISTORY**

a. Please list prior general liability insurance carried for each of the past three years. If none, state "NONE".

Insurance Carrier	Policy Number	Limits Liability	Deductible (if any)	Inception Premium	Expiration (MM/DD/YY)	Was this (MM/DD/YY)	Claims Made?
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**5 Year Loss History (attach further sheets if needed)  
(10 Years for Claims \$100,000 and Greater)**

Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved	Amount of Expenses Paid	Amount of Loss Reserved	Amount of Expenses Reserved	Open (O) or Closed (C)
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

c. (i) Is any claim above subject to a deductible or self-insured retention?  Yes  No  
 (ii) If Yes, are the amounts shown above inclusive or exclusive of the deductible or self-insured retention?  
 (iii) If inclusive, the amount of the deductible or self-insured retention is \$ \_\_\_\_\_.

d. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you?  Yes  No

If Yes, please attach an explanation.

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY. If policy is issued on a "CLAIMS MADE" basis, it provides coverage only for THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an occurrence basis, the policy provides coverage only for THOSE OCCURRENCES WHICH TAKE PLACE DURING THE POLICY PERIOD.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy.

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title (Officer, partner, etc.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.