



Commercial Insurance Questionnaire

Please complete the information below. IMPORTANT: This form is not an insurance policy – it is general information necessary to prepare a quotation. Note that many carriers require a complete signed carrier application specific to their product offerings.

GENERAL INFORMATION

Applicant Name: _____
 Business Name: _____
 DBA (if applicable): _____
 Mailing Street Address: _____
 City: _____ County: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____ Email: _____
 Location Street Address: _____
 City: _____ County: _____ State: _____ Zip: _____
 Principal Contact Name: _____
 Phone: _____ Email: _____
 Legal Entity (Check one):
 Corporation LLC Partnership Individual Not For Profit Other (please specify): _____
 Date Business Established: _____
 FEIN: _____
 SIC Code: _____
 Years in Operation: _____
 Years of Owner Experience in Industry: _____
 Description of Operations (Min. 10 Words): _____
 Number of Employees:
 Full Time _____ Part Time _____
 Gross Annual Payroll: \$ _____
 Gross Annual Revenue: \$ _____
 Insurance Coverage Requested (Check all that apply):
 Business Owners Policy (BOP) General Liability Professional Liability
 Commercial Auto Workers' Comp Other
 Current Insurance Carrier (If no insurance, enter "NONE"): _____
 Current Policy Expiration Date: _____
 Current Policy Retroactive Date: _____
 Current Limits: _____
 Desired Effective Date for New Policy: _____
 Desired Limits: _____
 Desired Deductible: _____

PROPERTY DETAILS

Are you requesting Property Coverage Yes No
 If no, list the current carrier - if no current insurance, enter "NONE". _____
 Is there Boiler Machinery Coverage Exposure Yes No
 Is there Earthquake Sprinkler Leakage Exposure Yes No
 Is there Underground Tank Leakage Exposure Yes No
 Do employees handle cash Yes No
 Building Ownership (Check one): Owned Triple Net Lease Lease

Location 1 Street Address: _____
City: _____ County: _____ State: _____ Zip: _____
Building Information
Insured sq feet: _____ Occupied sq feet: _____ Unoccupied sq feet: _____ Total: _____
Describe other occupancies: _____

Construction Type: _____ Number of stories: _____ % Sprinklered: _____
Building within city limits: Yes No
Year Built: _____
Year Renovated (Mandatory if building is greater than 10 years old):
Roof _____ Electrical _____ Plumbing _____ Heating/AC _____

Building Security
Fire Alarm: None Local Central
Burglar Alarm: None Local Central
Smoke Detectors: None Battery Hardwired

Property Values
Building: _____ Personal Property: _____ Stock: _____
Business Income
Annual Gross Revenue: _____ Estimate Annual Payroll: _____

Complete the Property section above for all additional locations.

GENERAL LIABILITY

Are you requesting General Liability Coverage: Yes No
If no, list the current carrier - if no current insurance, enter "NONE". _____
Desired Amount of General Liability Coverage: _____
Are Professional Services offered: Yes No
If yes, describe (Min. 10 Words): _____

Are any autos used exclusively for business use Yes No
Do any employees use a personal auto for business use Yes No
Are any web based services offered Yes No
Are credit card payments accepted Yes No
Is there a program to identify identity theft Yes No
Is there Underground Tank Leakage Exposure Yes No
Is there a Pollution Exposure Yes No

PROFESSIONAL LIABILITY

Are you requesting Professional Liability Coverage: Yes No
If no, list the current carrier - if no current insurance, enter "NONE". _____
Desired Amount of Professional Liability Coverage: _____
Describe Professional Services offered: (Min. 10 Words): _____

Does your firm provide services outside the U.S. Yes No
Percentage of Services: _____% US _____% Foreign
Does your firm use Independent Contractors (ICs) or Sub Contractors Yes No
Full Time _____ Part Time _____
Is there a formal Safety Plan: Yes No
What is the percentage of your firm's gross Fees paid to ICs or Sub Contractors last year:
Do you request Certificates of Insurance from ICs and Sub Contractors: Yes No
Do you have written agreements on every project: Yes No
Do ICs and Sub Contractors have written agreements: Yes No
Do you provide Professional Liability to your ICs and Sub Contractors: Yes No

MEDICAL PROFESSIONAL LIABILITY

Are you requesting Medical Professional Liability Coverage: Yes No
 If no, list the current carrier - if no current insurance, enter "NONE". _____
 Desired Amount of Professional Liability Coverage: _____
 Describe Professional Services offered: (Min. 10 Words): _____

Does your firm use Independent Contractors (ICs) or Sub Contractors Yes No
 Full Time _____ Part Time _____

Do you employ Physicians or Surgeons Yes No
 Is there a Medical Director Yes No
 Does the Medical Director have their own insurance Yes No
 Do you request Certificates of Insurance from ICs and Sub Contractors Yes No
 Do you have written agreements on every project Yes No
 Do ICs and Sub Contractors have written agreements Yes No
 Do you provide Professional Liability to your ICs and Sub Contractors Yes No
 Do you bill for Medicare/Medicaid Yes No

WORKERS' COMPENSATION

Are you requesting Workers' Compensation Coverage: Yes No
 If no, list the current carrier - if no current insurance, enter "NONE". _____

Number of Employees:
 Full Time _____ Part Time _____ Volunteer _____ TOTAL _____

Number of Independent Contractors (ICs):
 Full Time _____ Part Time _____

Are Medical Benefits Offered Yes No
 Do you offer Paid Vacation Yes No
 Is there a formal Safety Program Yes No
 Total Estimated Payroll: \$ _____

Payroll Information:

Class Code, Duties, or Description	# Employees		Estimated Payroll
	FT	PT	

For the Payroll Information section above for all locations

Employees/Owners to Be Excluded:

Name	Title	Estimated Payroll

ADDITIONAL COVERAGE INTERESTS

Check all that apply:

Commercial Umbrella	<input type="checkbox"/>	Employment Practices Liability	<input type="checkbox"/>
Buy/Sell Agreement	<input type="checkbox"/>	Bonds	<input type="checkbox"/>
Crime/Employee Dishonesty	<input type="checkbox"/>	Medicare/Medicaid Billing E&O	<input type="checkbox"/>
Cyber Liability	<input type="checkbox"/>	Regulatory Shut Down	<input type="checkbox"/>
Directors and Officer Liability	<input type="checkbox"/>	Other	<input type="checkbox"/>