

Commercial Lines New Business Quote Form

Producer: _____ Eff. Date: _____ Submitted Date: _____

Name: _____ DBA: _____

Mailing Address: _____

Contact: _____ Entity Type: Ind / Corp / LLC / Partnership / Other

FEIN or SSN: _____ DOB: _____

Bus Phone: _____ Bus Fax: _____ Cell: _____

Email: _____ Website: _____

Description of Business: _____

Year Business Started: _____

Prior / Current Carrier: _____ Target Premium: _____

Policy Numbers: _____

GL Limits: _____ / _____ Deductible: _____

Liability Code: _____ Exposure: _____ Liability Code: _____ Exposure: _____

Payroll w/o Owners: _____ Number of Owners: _____

Gross Receipts: _____ Sub-contractor Cost: _____

Employers Liability / Discrimination: _____ # of Employees: _____

Property

Location # 1 Address: _____

City: _____ State: _____ County: _____

Total SF: _____ Merchant SF: _____ City Limits: Inside / Outside

Interest: Owner / Tenant % Occupied: _____ Basement: Yes / No

Construction Type: _____ Year Built: _____ # of Stories: _____

Update Year Roof: _____ Plumbing: _____ Electrical: _____ Heating: _____

Building Coverage: _____ RC / ACV Co Ins%: _____ Ded: _____

Contents / BPP: _____ RC / ACV Co Ins%: _____ Ded: _____

Annual Revenue: _____ Sign: Metal / Frame / Other

Distance to Fire Hydrant: _____ Fire Station: _____

Is applicant a subsidiary of another entity? _____

Mechanical Breakdown / Boiler: _____

Other Occupancies: _____ Area Leased: _____

Alarm System: _____ Central Station: _____ % Sprinklered: _____ Central Station: _____

Front Exposure & Distance: _____ Rear Exposure & Distance: _____

Right Exposure & Distance: _____ Left Exposure & Distance: _____

Any exposure to flammables, explosives or chemicals? _____ If yes, please explain: _____

Lien Holder / Add. Insured: _____

Is a formal safety program in operation: _____ If yes, please describe: _____

Any policy or coverage declined, cancelled or non-renewed during prior 3 years? _____

Loss History – 3 Year Minimum (Or Attach): _____

Property – Additional Locations or Buildings If Needed

Location # 2 Address: _____

City: _____ State: _____ County: _____

Total SF: _____ Merchant SF: _____ City Limits: Inside / Outside

Interest: Owner / Tenant % Occupied: _____ Basement: Yes / No

Construction Type: _____ Year Built: _____ # of Stories: _____

Update Year: _____ Roof: _____ Plumbing: _____ Electrical: _____ Heating: _____

Building Coverage: _____ RC or ACV Co Ins%: _____ Ded: _____

Contents / BPP: _____ RC or ACV Co Ins%: _____ Ded: _____

Annual Revenue: _____ Sign: Metal / Frame / Other

Distance to Fire Hydrant: _____ Fire Station: _____

Is applicant a subsidiary of another entity? _____

Mechanical Breakdown / Boiler: _____

Other Occupancies: _____ Area Leased: _____

Alarm System: _____ Central Station: _____ % Sprinklered: _____ Central Station: _____

Front Exposure & Distance: _____ Rear Exposure & Distance: _____

Right Exposure & Distance: _____ Left Exposure & Distance: _____

Any exposure to flammables, explosives or chemicals? _____ If yes, please explain: _____

Lien Holder / Add. Insured: _____

Business Auto

Liability CSL: _____

UM/UIM: _____

Medical: _____

Hired / Non Owned: _____

Comprehensive Ded: _____ Collision Ded: _____

Garage Keepers Limit: _____ Ded: _____ Max Ded: _____

Open Lot Limit: _____ Ded: _____ Max Ded: _____

	Year	Make / Model	Body Type	VIN Number	Comp	Coll	Cost New
1.	_____	_____	_____	_____	Y / N	Y / N	_____
2.	_____	_____	_____	_____	Y / N	Y / N	_____
3.	_____	_____	_____	_____	Y / N	Y / N	_____
4.	_____	_____	_____	_____	Y / N	Y / N	_____
5.	_____	_____	_____	_____	Y / N	Y / N	_____

	Driver's Full Name	DOB	License #	State
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Where are autos garaged? _____

Do any drivers require SR22's? _____

Are any vehicles leased to others? Y / N If yes, please explain: _____

Additional Insured's / Loss Payee's _____

Inland Marine

Large Equipment over \$1000 Total Value: _____ Ded: _____

1. _____ Serial # _____ Value: _____

2. _____ Serial # _____ Value: _____

3. _____ Serial # _____ Value: _____

4. _____ Serial # _____ Value: _____

5. _____ Serial # _____ Value: _____

Small Tools Total Insured Value: _____ Ded: _____

Workers Compensation

Limits: _____ / _____ / _____ Exp-Mod: _____

Fed ID # _____ Owner SSN: _____

Class: _____ Payroll: _____ Class: _____ Payroll: _____

Class: _____ Payroll: _____ Class: _____ Payroll: _____

Owners / Corporate Officers Included / Excluded

Included Owners: Name: _____ DOB: _____ SSN: _____

 Name: _____ DOB: _____ SSN: _____

Umbrella

Limit: _____ Retained limit: _____