



COMMERCIAL INSURANCE APPLICATION

APPLICANT INFORMATION SECTION

DATE (MM/DD/YYYY)

AGENCY PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: CODE: SUB CODE: AGENCY CUSTOMER ID:	CARRIER POLICIES OR PROGRAM REQUESTED INDICATE SECTIONS ATTACHED <input type="checkbox"/> ACCOUNTS RECEIVABLE/ VALUABLE PAPERS <input type="checkbox"/> BOILER & MACHINERY <input type="checkbox"/> BUSINESS AUTO <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CRIME/MISCELLANEOUS CRIME <input type="checkbox"/> DEALERS <input type="checkbox"/> DRIVER INFO SCHEDULE	NAIC CODE: ELECTRONIC DATA PROC <input type="checkbox"/> EQUIPMENT FLOATER <input type="checkbox"/> GARAGE AND DEALERS <input type="checkbox"/> GLASS AND SIGN <input type="checkbox"/> INSTALLATION/BUILDERS RISK <input type="checkbox"/> OPEN CARGO <input type="checkbox"/> PROPERTY <input type="checkbox"/> TRANSPORTATION/ MOTOR TRUCK CARGO	UNDERWRITER POLICY NUMBER TRUCKERS/MOTOR CARRIER <input type="checkbox"/> UMBRELLA <input type="checkbox"/> VEHICLE SCHEDULE <input type="checkbox"/> WORKERS COMPENSATION <input type="checkbox"/> YACHT	UNDERWRITER OFF.
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STATUS OF TRANSACTION

PACKAGE POLICY INFORMATION

<input type="checkbox"/> QUOTE <input type="checkbox"/> ISSUE POLICY <input type="checkbox"/> RENEW <input type="checkbox"/> BOUND (Give Date and/or Attach Copy) <input type="checkbox"/> CHANGE DATE TIME AM PM <input type="checkbox"/> CANCEL	ENTER THIS INFORMATION WHEN COMMON DATES AND TERMS APPLY TO SEVERAL LINES, OR FOR MONOLINE POLICIES				
	PROPOSED EFF DATE	PROPOSED EXP DATE	BILLING PLAN	PAYMENT PLAN	AUDIT
			<input type="checkbox"/> DIRECT BILL		
			<input type="checkbox"/> AGENCY BILL	PACKAGE POLICY PREMIUM: \$	

APPLICANT INFORMATION

NAME (First Named Insured & Other Named Insureds)	MAILING ADDRESS INCL ZIP+4 (of First Named Insured)
FEIN OR SOC SEC # (of First Named Insured): E-MAIL ADDRESS(ES):	PHONE (A/C, No, Ext): WEBSITE ADDRESS(ES):
<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> CORPORATION <input type="checkbox"/> SUBCHAPTER "S" CORPORATION NOT FOR PROFIT ORG <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> JOINT VENTURE	<input type="checkbox"/> LLC NO OF MEMBERS AND MANAGERS CR BUREAU NAME: ID NUMBER:
INSPECTION CONTACT: PHONE (A/C, No, Ext): E-MAIL ADDRESS:	ACCOUNTING RECORDS CONTACT: PHONE (A/C, No, Ext): E-MAIL ADDRESS:

PREMISES INFORMATION

ACORD 823 attached for additional premises

LOC #	BLD #	STREET, CITY, COUNTY, STATE, ZIP+4	CITY LIMITS	INTEREST	YR BUILT	# EMPLOYEES	ANNUAL REVENUES	% OCCUPIED
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS BY PREMISE(S)

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES		Y/N
1a	IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ?	<input type="checkbox"/>
1b	DOES THE APPLICANT HAVE ANY SUBSIDIARIES?	<input type="checkbox"/>
2	IS A FORMAL SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>
3	ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS?	<input type="checkbox"/>
4	ANY CATASTROPHE EXPOSURE?	<input type="checkbox"/>
5	ANY OTHER INSURANCE WITH THIS COMPANY OR BEING SUBMITTED?	<input type="checkbox"/>
6	ANY POLICY OR COVERAGE DECLINED, CANCELLED OR NON-RENEWED DURING THE PRIOR THREE (3) YEARS? (Not applicable in MO)	<input type="checkbox"/>
7	ANY PAST LOSSES OR CLAIMS RELATING TO SEXUAL ABUSE OR MOLESTATION ALLEGATIONS, DISCRIMINATION OR NEGLIGENT HIRING?	<input type="checkbox"/>
8	DURING THE LAST FIVE YEARS (TEN IN RI), HAS ANY APPLICANT BEEN INDICTED FOR OR CONVICTED OF ANY DEGREE OF THE CRIME OF FRAUD, BRIBERY, ARSON OR ANY OTHER ARSON-RELATED CRIME IN CONNECTION WITH THIS OR ANY OTHER PROPERTY? (In RI, this question must be answered by any applicant for property insurance. Failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one year of imprisonment).	<input type="checkbox"/>
9	ANY UNCORRECTED FIRE CODE VIOLATIONS?	<input type="checkbox"/>
10	ANY BANKRUPTCIES, TAX OR CREDIT LIENS AGAINST THE APPLICANT IN THE PAST FIVE (5) YEARS?	<input type="checkbox"/>
11	HAS BUSINESS BEEN PLACED IN A TRUST? IF "YES", NAME OF TRUST:	<input type="checkbox"/>
12	ANY FOREIGN OPERATIONS, FOREIGN PRODUCTS DISTRIBUTED IN USA, OR US PRODUCTS SOLD/DISTRIBUTED IN FOREIGN COUNTRIES? (If "YES", attach ACORD 815 for Liability Exposure and/or ACORD 816 for Property Exposure)	<input type="checkbox"/>
REMARKS/PROCESSING INSTRUCTIONS (Attach additional sheets if more space is required)		
COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT (Not applicable in all states, consult your agent or broker for your state's requirements)		
NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT POLICY RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.		
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR, or VT; in DC, LA, ME, TN, VA and WA, insurance benefits may also be denied) IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.		
THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.		
PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	NATIONAL PRODUCER NUMBER
APPLICANT'S SIGNATURE	DATE	

PRIOR CARRIER INFORMATION

LINE	CATEGORY	CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE	
GENERAL COMMERCIAL LIABILITY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	RETRO DATE																
	EFF-EXP DATE																
	GENERAL AGGREGATE																
	PRODUCTS COMP OP AGGREGATE																
	PERSONAL & ADV INJ																
	EACH OCCURRENCE																
	FIRE DAMAGE																
	MEDICAL EXPENSE																
	BODILY OCCURRENCE INJURY AGGREGATE																
	PROPERTY OCCURRENCE DAMAGE AGGREGATE																
	COMBINED SINGLE LIMIT																
	MODIFICATION FACTOR																
TOTAL PREMIUM																	
AUTOMOBILE LIABILITY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	COMBINED SINGLE LIMIT																
	BODILY EA PERSON INJURY EA ACCIDENT																
	PROPERTY DAMAGE																
	MODIFICATION FACTOR																
	TOTAL PREMIUM																
PROPERTY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	BUILDING AMT																
	PERS PROP AMT																
	MODIFICATION FACTOR																
TOTAL PREMIUM																	
	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	LIMIT																
	MODIFICATION FACTOR																
	TOTAL PREMIUM																

LOSS HISTORY

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY)

DATE OF OCCURRENCE	LINE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	CLAIM STATUS OPEN/CLSD

REMARKS NOTE: FIDELITY REQUIRES A FIVE YEAR LOSS HISTORY

ATTACHMENTS
STATE SUPPLEMENT(S) (If applicable)



**COMMERCIAL INSURANCE APPLICATION SUPPLEMENT
ADDITIONAL PREMISES INFORMATION SECTION**

AGENCY		APPLICANT/NAMED INSURED	
		COMPANY:	EFFECTIVE DATE
CODE:	SUB CODE:	POLICY #:	

PREMISES INFORMATION

LOC #	BLD #	STREET, CITY, COUNTY, STATE, ZIP+4	CITY LIMITS	INTEREST	YR BUILT	# EMPLOYEES	ANNUAL REVENUES	% OCCUPIED
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				
			INSIDE	OWNER				
			OUTSIDE	TENANT				

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS BY PREMISE(S)



EQUIPMENT FLOATER SECTION

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext):	APPLICANT				
	FAX (A/C, No):	PROPOSED EFF. DATE	PROPOSED EXP. DATE	BILLING PLAN	PAYMENT PLAN	AUDIT
				AGENCY		
				DIRECT		
CODE:	SUBCODE:	FOR COMPANY USE ONLY				
AGENCY CUSTOMER ID						

TERRITORY OF OPERATION

TYPE OF OPERATION

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COVERAGE/DEDUCTIBLE

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EQUIPMENT STORAGE

LOC. #	MO. IN STORAGE	MAXIMUM VALUE		TYPE OF SECURITY
		IN BUILDING	OUTSIDE	
		\$	\$	
		\$	\$	
		\$	\$	

UNSCHEDULED EQUIPMENT

DESCRIPTION	MAXIMUM ITEM	AMT. OF INSURANCE	% COINS

ADDITIONAL INTEREST/CERTIFICATE RECIPIENTS

ACORD 45 Attached

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER	
<input type="checkbox"/> LOSS PAYEE					LOCATION:	BUILDING:
<input type="checkbox"/> LIENHOLDER					SCHEDULED ITEM NUMBER:	
					OTHER	
ITEM DESCRIPTION:						
INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER	
<input type="checkbox"/> LOSS PAYEE					LOCATION:	BUILDING:
<input type="checkbox"/> LIENHOLDER					SCHEDULED ITEM NUMBER:	
					OTHER	
ITEM DESCRIPTION:						
INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER	
<input type="checkbox"/> LOSS PAYEE					LOCATION:	BUILDING:
<input type="checkbox"/> LIENHOLDER					SCHEDULED ITEM NUMBER:	
					OTHER	
ITEM DESCRIPTION:						

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. EQUIPMENT RENTED, LOANED TO/FROM OTHERS WITH/WITHOUT OPERATORS?	<input type="checkbox"/>
2. IS APPLICANT OPERATING EQUIPMENT NOT LISTED HERE?	<input type="checkbox"/>
3. PROPERTY USED UNDERGROUND?	<input type="checkbox"/>
4. ANY WORK DONE AFLOAT?	<input type="checkbox"/>

SCHEDULED EQUIPMENT

% COINSURANCE

#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$
#	TYPE	DESCRIPTION	ID # / SERIAL NO.	NEW / USED	DATE PURCHASED
	MANUFACTURER	MODEL	MODEL YEAR	CAPACITY	AMOUNT OF INSURANCE \$

ACORD™ ADDITIONAL INTEREST

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext): FAX (A/C, No):	APPLICANT (First Named Insured)	PHONE (A/C, No, Ext):
CODE:	SUB CODE:	EFFECTIVE DATE	EXPIRATION DATE
AGENCY CUSTOMER ID		POLICY NUMBER:	
		ACCOUNT NUMBER	

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					LOCATION:
<input type="checkbox"/> LOSS PAYEE					BUILDING:
<input type="checkbox"/> MORTGAGEE					VEHICLE:
<input type="checkbox"/> LIENHOLDER					BOAT:
<input type="checkbox"/> EMPLOYEE AS LESSOR					SCHEDULED ITEM NUMBER:
ITEM DESCRIPTION:					OTHER

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					LOCATION:
<input type="checkbox"/> LOSS PAYEE					BUILDING:
<input type="checkbox"/> MORTGAGEE					VEHICLE:
<input type="checkbox"/> LIENHOLDER					BOAT:
<input type="checkbox"/> EMPLOYEE AS LESSOR					SCHEDULED ITEM NUMBER:
ITEM DESCRIPTION:					OTHER

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					LOCATION:
<input type="checkbox"/> LOSS PAYEE					BUILDING:
<input type="checkbox"/> MORTGAGEE					VEHICLE:
<input type="checkbox"/> LIENHOLDER					BOAT:
<input type="checkbox"/> EMPLOYEE AS LESSOR					SCHEDULED ITEM NUMBER:
ITEM DESCRIPTION:					OTHER

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					LOCATION:
<input type="checkbox"/> LOSS PAYEE					BUILDING:
<input type="checkbox"/> MORTGAGEE					VEHICLE:
<input type="checkbox"/> LIENHOLDER					BOAT:
<input type="checkbox"/> EMPLOYEE AS LESSOR					SCHEDULED ITEM NUMBER:
ITEM DESCRIPTION:					OTHER

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					LOCATION:
<input type="checkbox"/> LOSS PAYEE					BUILDING:
<input type="checkbox"/> MORTGAGEE					VEHICLE:
<input type="checkbox"/> LIENHOLDER					BOAT:
<input type="checkbox"/> EMPLOYEE AS LESSOR					SCHEDULED ITEM NUMBER:
ITEM DESCRIPTION:					OTHER

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					LOCATION:
<input type="checkbox"/> LOSS PAYEE					BUILDING:
<input type="checkbox"/> MORTGAGEE					VEHICLE:
<input type="checkbox"/> LIENHOLDER					BOAT:
<input type="checkbox"/> EMPLOYEE AS LESSOR					SCHEDULED ITEM NUMBER:
ITEM DESCRIPTION:					OTHER

INTEREST	RANK:	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	INTEREST IN ITEM NUMBER
<input type="checkbox"/> ADDITIONAL INSURED					LOCATION:
<input type="checkbox"/> LOSS PAYEE					BUILDING:
<input type="checkbox"/> MORTGAGEE					VEHICLE:
<input type="checkbox"/> LIENHOLDER					BOAT:
<input type="checkbox"/> EMPLOYEE AS LESSOR					SCHEDULED ITEM NUMBER:
ITEM DESCRIPTION:					OTHER

EQUIPMENT SUPPLEMENTAL APPLICATION

This app must be attached to the Acord General Applicant information application-Acord 125

QUOTE DATE		AGENCY NAME	
COVER DATE		AGENCY CONTACT	
EXP. DATE		AGENCY PHONE NO.	()
POLICY TERM		AGENCY FAX NO.	()
DOES AGENT KNOW PROPOSED INSURED PERSONALLY		() YES	() NO
WHAT OTHER COVERAGES DO YOU WRITE FOR THIS INSURED		NO. OF YEARS	

INSURED INFORMATION

INSURED NAME	SS#
INSURED DBA	FED ID #
PHYSICAL ADDRESS: MAILING ADDRESS:	PHONE#
CITY	STATE ZIP
TYPE BUSINESS	YRS IN BUSINESS
PRIOR CARRIER	5 YR LOSS AMT \$
EXPLANATION OF LOSS	LOSS DATE:
RADIUS OF OPERATION	AVG YRS EXPERIENCE OF OPERATORS
#PIECES OWNED	#PIECES INSURED

EQUIPMENT DETAIL

NOTE TYPE OF FIRE SUPPRESSION EQUIPMENT BY EACH MACHINE LISTED BELOW (I.E., WATER TANK, FIRE EXTINGUISHER, ETC.)

UNIT	YEAR	MAKE & MODEL	FIRE	SERIAL NO.	INS. AMT.
#1					
#2					
#3					
#4					
#5					

VERIFY YEAR MODELS ON ALL EQUIPMENT

BILLING TYPE: AGENCY BILL

What Company writes the W/C and GL for the insured? _____
 Provide overview of maintenance program. _____
 For Forestry/Construction, describe cool down procedures.
 Provide all security measures for equipment during non working hours and weekends.

 Is applicant operating equipment not listed here? _____
 Any property used underground? _____
 Any work done afloat or any waterbourne equipment? _____

RENTED/LEASED EQUIPMENT

Any equipment rented or loaned to others with/ without operator? If yes, please explain.

Any equipment rented or loaned from others? If requesting Rented/Leased coverage, answer questions below.

Prior 12 and estimated next 12 months rental expenditures to rent equipment from others?

Max and average per item value requested? _____

Max and average occurrence limit requested? _____

CRANES

Do the operators have more than 5 years experience? _____

Are all operators certified? _____

Verify all cranes are owned. If Rented/Leased, which items and length of lease or rental? _____

What is the crane used for? Is Overload Coverage requested? _____

Are all Cranes equipped with weight of load monitoring devices that automatically shut down the machine if the cargo exceed's the vehicle's maximum lifting capacity? _____

Can the insured override the weight of load capacity? _____

Describe the safety equipment and procedures in place on cranes. _____

RIGGING/HOOK

Prior 12 and estimated next 12 months rigging receipts? _____

Average and maximum height of lift? _____

Average and maximum "on-hook" values? _____

Description of typical items lifted? _____

Can the insured override the weight of load capacity? _____

THE UNDERSIGNED CERTIFIES THAT THE ANSWERS HEREIN ARE TRUE AND CORRECT TO THE BEST OF HIS\HER KNOWLEDGE. SIGNING OF THE APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF A CONTRACT SHOULD A POLICY BE ISSUED.

LOSS PAYEE _____

SIGNATURES

APPLICANT:

PRODUCER

BPAPP 08/07