



### 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

**ALLIED MEDICAL AND MEDICAL PROFESSIONAL LIABILITY**

Are you requesting Allied 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"/>