



CUSTOMER DATA SHEET

Company Name:					
Address:					
City:		State:		Zip Code:	
Contact Phone:			Fax:		
Contact Name:			Federal Tax ID:		
Years in Business:			Standard Industrial Code (SIC):		
Corporation	Partnership	Sole Proprietorship	LLC	LLP	Other
Principals:		Title:		% of Ownership:	

DESCRIPTION OF OPERATIONS:

LOCATIONS:

GENERAL LIABILITY:

Estimated Annual Payroll	Estimated Annual Sales/Receipts

GENERAL INFORMATION: Please circle Yes or No
Explain all "yes" responses (for all past or present operations)

1. Any Medical Facilities provided or medical professionals employed or contracted?	Yes	No	11. Sporting or social events sponsored?	Yes	No
2. Any exposure to radioactive/nuclear materials?	Yes	No	12. Any structural alterations contemplated?	Yes	No
3. Do/have past, present or discontinued operations involve(d) storing, treating, discharging, applying, disposing, or transporting of hazardous material?	Yes	No	13. Any demolition exposure contemplated?	Yes	No
4. Any operations sold, acquired, or discontinued in the last 5 years?	Yes	No	14. Has applicant been active in or is currently active in joint ventures?	Yes	No
5. Machinery or Equipment loaned or rented to others?	Yes	No	15. Do you lease employees to or from other employers?	Yes	No
6. Watercraft, docks, floats owned or rented to others?	Yes	No	16. Is there labor interchange with any other business?	Yes	No
7. Any parking facilities owned/rented?	Yes	No	17. Day care facilities operated or controlled?	Yes	No
8. Is a fee charged for parking?	Yes	No	18. Any crimes occurred or been attempted on your premises in the last 3 years?	Yes	No
9. Recreation facilities provided?	Yes	No	19. Is there a formal, written safety & security policy on effect?	Yes	No
10. Is there a swimming pool on the premises?	Yes	No	20. Does the businesses' promotional literature make any representations about the safety or security of the premises?	Yes	No

BUSINESS AUTO:

- Attach a Current Driver List (showing Name, Date of Birth & TDL #)
- Attached a Current Vehicle List (showing Year, Make, Model, VIN #, Value of Vehicle)

WORKERS COMPENSATION:

CLASS CODE	JOB DESCRIPTION	PAYROLL	# OF EMPLOYEES (FULL/PART TIME)

OWNERS & OFFICERS: (Included or Excluded)

NAME	DESCRIPTION OF DUTIES	% OF OWNERSHIP

Do you currently have a Safety/Loss Control Program? Yes or No
(If Yes, please provide the following:)

- Date Started:
- Name of Company Providing Service:
- Attached or Describe Safety Program:

PRIOR CARRIER/LOSS INFORMATION HISTORY:

Year	Carrier & Policy #	Premium	# of Annual Claims	Experience Mod	Total Paid Losses

PROPERTY: (Information Needed for Each Building)

Construction Type: _____ Number of Stories: _____ Year Built: _____
Roof Type: _____ Total Area in Square Ft.: _____
Building Limit \$: _____ Contents Limit \$: _____

Building Improvements:

Wiring Year: _____ Plumbing Year: _____ Roofing Year: _____ Heating Year: _____
Burglar Alarm Type: _____ Central Station: _____
Burglar Alarm System Installed and Serviced By: _____