



INSURANCE AGENCY, INC.
 PRIMARY / EXCESS AND SURPLUS LINES BROKERS
 Ten Granite Street Suite 2
 Quincy, MA 02169
 617.471.7171 Fax: 617.471.7180
 www.xsbrokers.com

General Liability Application

Applicant's Name	_____
Mailing Address	_____ _____
Location	_____ _____

Agent Name	_____
Address	_____ _____
Agent No.:	_____

PROPOSED EFFECTIVE DATE:

From _____ To _____
 12:01 A.M., Standard Time at the address of the Applicant.

LIMITS OF LIABILITY REQUESTED

PREMIUMS

General Aggregate	\$	Premises/Operations
Products & Completed Operations Aggregate	\$	\$
Personal & Advertising Injury	\$	Products/Completed Operations
Each Occurrence	\$	\$
Fire Damage (any one fire)	\$	Other
Medical Expense (any one person)	\$	\$
Other Coverages, Restrictions, and/or Endorsements		Total
Deductible	\$	\$

APPLICANT/PREMISES/OPERATIONS INFORMATION

1. Describe all business operations conducted by applicant: _____

2. Premises information (attach schedule if necessary):

Loc. No.	Street, City, County, State, Zip Code	Interest	Part Occupied

3. Applicant is: Individual Corporation Partnership Joint Venture Limited Liability Company
 Nonprofit Other (Specify): _____

4. Inspection/Audit:

Inspection (contact and phone): _____

Accounting records (contact and phone): _____

5. Management: Number of years in operation: _____ If new operation, number of years related experience: _____

6. Total number of employees: _____

GENERAL INFORMATION (Explain all "yes" responses.)

	Yes	No		Yes	No
1. Exposure to flammables, explosives, chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	11. Any parking facilities owned/rented?	<input type="checkbox"/>	<input type="checkbox"/>
2. Exposure to asbestos?	<input type="checkbox"/>	<input type="checkbox"/>	12. Fee charged for parking?	<input type="checkbox"/>	<input type="checkbox"/>
3. Exposure to radioactive materials?	<input type="checkbox"/>	<input type="checkbox"/>	13. Does applicant have Workers' Compensation coverage in force?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do operations involve storing, treating, discharging, applying, disposing or transporting of hazardous material (e.g., landfills, wastes, fuel tanks, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	14. Does insured subcontract work?	<input type="checkbox"/>	<input type="checkbox"/>
5. Sporting/social events sponsored?	<input type="checkbox"/>	<input type="checkbox"/>	15. Certificates of insurance required from all subcontractors?	<input type="checkbox"/>	<input type="checkbox"/>
6. Any watercraft, docks, floats owned, hired, or leased?	<input type="checkbox"/>	<input type="checkbox"/>	16. Does the applicant lease employees?	<input type="checkbox"/>	<input type="checkbox"/>
7. Any operations sold, acquired, or discontinued in last five years?	<input type="checkbox"/>	<input type="checkbox"/>	17. Any demolition exposure contemplated?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is applicant a subsidiary of another entity or does applicant have any subsidiaries?	<input type="checkbox"/>	<input type="checkbox"/>	18. Any structural alterations contemplated?	<input type="checkbox"/>	<input type="checkbox"/>
9. Machinery/equipment loaned/rented to others?	<input type="checkbox"/>	<input type="checkbox"/>	19. Recreational facilities provided?	<input type="checkbox"/>	<input type="checkbox"/>
10. Swimming pool on premises?	<input type="checkbox"/>	<input type="checkbox"/>	20. Any policy or coverage declined, cancelled or nonrenewed during last three years? (not applicable in Missouri)	<input type="checkbox"/>	<input type="checkbox"/>
			If yes, please explain _____		

PRIOR CARRIER INFORMATION

	Year:	Year:	Year:	Year:	Year:
Carrier					
Policy No.					
Total Premium					

LOSS HISTORY—FIVE YEAR PERIOD

Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)

ADDITIONAL INSURED INFORMATION

Name	Address

SCHEDULE OF HAZARDS

Loc. No.	Classification	Class. Code	Premium Bases: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem./Ops.	Products/Comp. Ops.	Prem./Ops.	Products/Comp. Ops.

This application does not bind YOU nor US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties.

APPLICANT'S SIGNATURE _____ Date _____

PRODUCER'S SIGNATURE _____ Date _____

AGENT NAME _____ AGENT LICENSE NUMBER _____
(Applicable to Florida Agents Only.)

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

ANSWER ALL QUESTIONS – IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE