Commercial Insurance Questionnaire

Please provide all information below so that a quotation may be obtained.

GENERAL INFORMATION:

NAMED INSURED: ______________________________

D/B/A: ______________________________

ADDRESS OF BUSINESS: ______________________________
(Location #1)
____

MAILING ADDRESS: ______________________________
(If different than physical address)
____

PHONE NUMBER: ______________________________

FAX NUMBER: ______________________________

CONTACT PERSON: ______________________________

EMAIL ADDRESS: ______________________________

WEBSITE: ______________________________

BUSINESS INFORMATION:

YEAR BUSINESS STARTED:		
# OF YEARS EXPERIENCE :		
# OF FULL TIME EMPLOYEES:		
# OF PART TIME EMPLOYEES:		
FEDERAL ID #:		
TYPE OF BUSINESS:	________ "C" Corporation	________ "S" Corporation
	________ Partnership	________ Individual
	________ LLC	________ LLP

COMPLETE DESCRIPTION OF BUSINESS OPERATIONS: ______________________________

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WORKERS' COMPENSATION:

	CLASS CODE	CLASS CODE	CLASS CODE	CLASS CODE
CLASS CODE:				
CLASS DESCRIPTION:				
PAYROLL:				
# OF FULL TIME EMP:				
# OF PART TIME EMP:				

CORPORATE OFFICERS:

	PRESIDENT	V. PRESIDENT	SECRETARY	TREASURER
NAME:				
DATE OF BIRTH:				
SOCIAL SECURITY #:				
% OF OWNERSHIP:				
INCLUDED/EXCLUDED:				
ANNUAL SALARY:				
OFFICERS DUTIES:				

NOTES: