



AGENCY CUSTOMER ID: _____

UMBRELLA / EXCESS SECTION

DATE (MM/DD/YYYY)

IMPORTANT - If CLAIMS MADE is checked in the POLICY INFORMATION section below, this is an application for a claims-made policy.

AGENCY A Biz Action Insure Me Agency		CARRIER		NAIC CODE
POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)		

POLICY INFORMATION

TRANSACTION TYPE				LIMIT OF LIABILITY		RETAINED LIMIT
NEW RENEWAL	UMBRELLA EXCESS	OCCURRENCE CLAIMS MADE	RETROACTIVE DATE		\$ EA OCC	\$
			PROPOSED	CURRENT		
EXPIRING POL #:						FIRST DOLLAR DEFENSE (Y / N)

EMPLOYEE BENEFITS LIABILITY

LIMIT OF INSURANCE (Ea Employee)	AGGREGATE LIMIT FOR EBL	RETAINED LIMIT FOR EBL	RETROACTIVE DATE FOR EBL
\$	\$	\$	
NAME OF BENEFIT PROGRAM			

PRIMARY LOCATION & SUBSIDIARIES (ACORD 125)

#	NAME AND LOCATION OF PRIMARY AND ALL SUBSIDIARY COMPANIES (Describe Operations)	ANNUAL PAYROLL	ANN GROSS SALES	FOREIGN GROSS SALES	# EMPL
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				

UNDERLYING INSURANCE

LIST ALL LIABILITY / COMPENSATION POLICIES IN FORCE TO APPLY AS UNDERLYING INSURANCE							+ - RATING MOD
TYPE	CARRIER / POLICY NUMBER	POLICY EFF DATE	POLICY EXP DATE	LIMITS		ANNUAL RENEWAL PREMIUM	
AUTOMOBILE LIABILITY				CSLEA ACC	\$	\$	
				BIEA ACC	\$	\$	
				BIEA PER	\$	\$	
				PDEA ACC	\$	\$	
GENERAL LIABILITY TYPE FOOD OCCUR CLAIMS MADE				EACH OCCURRENCE	\$	PREM / OPS	
				GENERAL AGGR	\$	\$	
				PROD & COMP OPS AGGREGATE	\$	PRODUCTS	
				PERSONAL & ADV INJURY	\$	\$	
				DAMAGE TO RENTED PREMISES	\$	OTHER	
				MEDICAL EXPENSE	\$	\$	
					\$	\$	
EMPLOYERS LIABILITY				EACH ACCIDENT	\$	\$	
				DISEASE EACH EMPLOYEE	\$	\$	
				DISEASE POLICY LIMIT	\$	\$	
					\$	\$	

UNDERLYING INSURANCE (continued)

AGENCY CUSTOMER ID: _____

UNDERLYING GENERAL LIABILITY INFORMATION (Explain all "YES" responses)

1. ARE DEFENSE COSTS: WITHIN AGGREGATE LIMITS? A SEPARATE LIMIT? UNLIMITED?

2. INDICATE THE EDITION DATE OF THE ISO FORM OR SIMILAR FILING FOR THE UNDERLYING COVERAGE:

3. HAS ANY PRODUCT, WORK, ACCIDENT, OR LOCATION BEEN EXCLUDED, UNINSURED OR SELF INSURED FROM ANY PREVIOUS COVERAGE? (Y / N)

4. FOR CLAIMS MADE, INDICATE RETROACTIVE DATE OF CURRENT UNDERLYING POLICY:

5. FOR CLAIMS MADE, INDICATE ENTRY DATE INTO UNINTERRUPTED CLAIMS MADE COVERAGE:

6. FOR CLAIMS MADE, WAS "TAIL" COVERAGE PURCHASED FOR ANY PREVIOUS PRIMARY OR EXCESS POLICY? (Y / N) EFF. DATE: _____

CHECK ALL COVERAGES IN UNDERLYING POLICIES. ALSO CHECK IF ANY EXPOSURES ARE PRESENT FOR EACH COVERAGE. PROVIDE AN EXPLANATION. EXPLAIN IF DIFFERENT LIMITS, EXTENSIONS, OR EXCLUSIONS. EXPLAIN ANY SPECIAL COVERAGES BEYOND STANDARD FORMS. **EXPLAIN ALL EXPOSURES.**

CHECK IF APPROPRIATE		COVERAGE	EXPOSURE	COVERAGE	EXPOSURE
<input type="checkbox"/>	ANY AUTO (SYMBOL 1)	CARE, CUSTODY, CONTROL	<input type="checkbox"/>	PROFESSIONAL LIABILITY (E&O)	<input type="checkbox"/>
<input type="checkbox"/>	CGL - CLAIMS MADE	EMPLOYEE BENEFIT LIABILITY	<input type="checkbox"/>	VENDORS LIABILITY	<input type="checkbox"/>
<input type="checkbox"/>	CGL - OCCURRENCE	FOREIGN LIABILITY / TRAVEL	<input type="checkbox"/>	WATERCRAFT LIABILITY	<input type="checkbox"/>
<input type="checkbox"/>		GARAGEKEEPERS LIABILITY	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	AIRCRAFT LIABILITY	INCIDENTAL MEDICAL MALPRACTICE	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	AIRCRAFT PASSENGER LIABILITY	LIQUOR LIABILITY	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	ADDITIONAL INTERESTS	POLLUTION LIABILITY	<input type="checkbox"/>		<input type="checkbox"/>

UNDERLYING INSURANCE COVERAGE INFORMATION (INCLUDE ALL RESTRICTIONS; e.g. LASER ENDORSEMENTS, DISCRIMINATION, SUBROGATION WAIVERS, OR EXTENSIONS OF COVERAGE) Attach ACORD 101, Additional Remarks Schedule, if more space is required.

CLAIMS
WEITER

EXPERIENCE: (GIVE DETAILS OF ALL LIABILITY CLAIMS EXCEEDING \$10,000 OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS, DURING THE PAST FIVE (5) YEARS, INSURED OR NOT. SPECIFY DATE, COVERAGE, DESCRIPTION, AMOUNT PAID, AMOUNT OUTSTANDING) Attach ACORD 101, Additional Remarks Schedule, if more space is required.

NO SUCH CLAIMS

CARE, CUSTODY, CONTROL

LOC	PROPERTY TYPE	VALUE	A*	B*	C*	D*	SQ FT OF BLDG OCC
	REAL						
	PERSONAL						
OCCUPANCY/DESCRIPTION OF PERSONAL PROPERTY							
*APPLICANT: [A] IS HELD HARMLESS IN THE LEASE, [B] HAS A WAIVER OF SUBROGATION, [C] IS A NAMED INSURED IN THE FIRE POLICY, [D] OTHER (specify)							

VEHICLES

TYPE	# OWNED	# NON-OWNED	# LEASED	PROPERTY HAULED	RADIUS (MILES)		
					LOCAL	INTER-MEDIATE	LONG DISTANCE
PRIVATE PASSENGER							
TRUCKS	LIGHT						
	MEDIUM						
	HEAVY						
	EX. HEAVY						
TRUCKS / TRACTORS	HEAVY						
	EX. HEAVY						
BUSES							

ADDITIONAL EXPOSURES

AGENCY CUSTOMER ID: _____

EXPLAIN ALL YES RESPONSES, PROVIDE OTHER INFORMATION REQUIRED	Y / N
ADVERTISERS LIABILITY	
1. MEDIA USED: ANNUAL COST: \$	
2. ARE SERVICES OF AN ADVERTISING AGENCY USED?	
3. ANY COVERAGE PROVIDED UNDER AGENCY'S POLICY?	
AIRCRAFT LIABILITY	
4. DOES APPLICANT OWN / LEASE / OPERATE AIRCRAFT?	
AUTO LIABILITY	
5. ARE EXPLOSIVES, CAUSTICS, FLAMMABLES OR OTHER DANGEROUS CARGO HAULED?	
6. ARE PASSENGERS CARRIED FOR A FEE?	
7. ANY UNITS NOT INSURED BY UNDERLYING POLICIES?	
8. ARE ANY VEHICLES LEASED OR RENTED TO OTHERS?	
9. ARE HIRED AND NON-OWNED COVERAGES PROVIDED?	
CONTRACTORS LIABILITY	
10. IS BRIDGE, DAM, OR MARINE WORK PERFORMED?	
11. DESCRIBE TYPICAL JOBS PERFORMED (Attach ACORD 101, Additional Remarks Schedule, if more space is required)	
12. DESCRIBE AGREEMENT (Attach ACORD 101, Additional Remarks Schedule, if more space is required)	
13. DOES APPLICANT OWN, RENT, OR OTHERWISE USE CRANES?	
14. DO SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN APPLICANT?	
EMPLOYERS LIABILITY	
15. IS APPLICANT SELF-INSURED IN ANY STATE?	
16. SUBJECT TO: JONESACT FELA STOPGAP OTHER:	
INCIDENTAL MALPRACTICE LIABILITY	
17. IS A HOSPITAL OR FIRST AID FACILITY MAINTAINED?	
18. ARE COVERAGES PROVIDED FOR DOCTORS / NURSES?	
19. INDICATE # OF DOCTORS: NURSES: BEDS:	

AGENCY CUSTOMER ID:

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

SIGNATURE

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, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

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.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, 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, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

IF THE COMPANY TO WHICH I AM APPLYING OFFERS UNINSURED MOTORISTS (UM) AND/OR UNDERINSURED MOTORISTS (UIM) COVERAGE IN MY STATE:

UNINSURED MOTORISTS (UM) COVERAGE: \$ _____ * UNDERINSURED MOTORISTS (UIM) COVERAGE: \$ _____ *

* IF APPLICABLE IN YOUR STATE

APPLICABLE ONLY IN LOUISIANA, NEW HAMPSHIRE, VERMONT AND WISCONSIN

APPLICABLE ONLY IN LOUISIANA:

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS, UM LIMITS LOWER THAN MY LIABILITY LIMITS, OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. OR 2. I REJECT UM COVERAGE

(INITIALS)

APPLICABLE ONLY IN NEW HAMPSHIRE:

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. OR 2. I REJECT UM COVERAGE

(INITIALS)

APPLICABLE ONLY IN VERMONT:

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED UM COVERAGE EQUAL TO MY LIABILITY LIMITS. I HAVE SELECTED THE LIMITS INDICATED IN THIS APPLICATION.

APPLICABLE ONLY IN WISCONSIN:

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) COVERAGE AND UNDERINSURED MOTORIST COVERAGE IN ITS ENTIRETY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. OR 2. I REJECT UM COVERAGE

(INITIALS)

3. I SELECT UIM LIMITS INDICATED IN THIS APPLICATION. OR 4. I REJECT UIM COVERAGE

(INITIALS)

IMPORTANT - THE STATEMENTS (ANSWERS) GIVEN ABOVE ARE TRUE AND ACCURATE. THE APPLICANT HAS NOT WILLFULLY CONCEALED OR MISREPRESENTED ANY MATERIAL FACT OR CIRCUMSTANCE CONCERNING THIS APPLICATION. THIS APPLICATION DOES NOT CONSTITUTE A BINDER.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print) A BIZ ACTION INSURANCE AGENCY	STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER