



**BROKERING AGENT'S REGISTER NUMBER #:** \_\_\_\_\_

(IMPORTANT: IN ORDER FOR COVERAGE TO BE BOUND ALL QUESTIONS MUST BE ANSWERED COMPLETELY BEFORE SUBMISSION AND INCLUDE TOTAL NET PREMIUM. IF ADDITIONAL SPACE IS NEEDED, UNSE ADDITIONAL APPLICATION. COVERAGE MAY ONLY BE BOUND BY THE BROKERING AGENT AFTER RECEIVING TELEPHONIC, ELECTRONIC OR FACSIMIL APPROVAL FROM THE INSURER.)

**ARTISAN / CONTRACTORS LIABILITY APPLICATION**

NEW  RENEWAL

Proposed Effective Date: \_\_\_\_\_ To \_\_\_\_\_ Policy Number: \_\_\_\_\_

Applicant/Insured:					
DBA:			Producers Name & Address:		
Address:					
City & State:		Zip:			
Inspection Contact:		Phone:			
Accounting Contact:		Phone:		Agent's 2-20 License #:	
<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Prof Corp.	Years in Business: _____	
Location 1:	Street: _____	City & State: _____	County: _____	Zip: _____	
Location 2:	Street: _____	City & State: _____	County: _____	Zip: _____	

**Business Information:**

Business of Insured (Please Describe):	
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**Commercial General Liability – Occurrence Form:**

Coverage	Limits	
Each Occurrence / Aggregate CSL	\$ _____	
Products & Completed Operation Aggregate	\$ _____	*Rating and Premium Basis:
Personal & Advertising Injury	\$ _____	(P) Payroll-Per \$1,000 / Pay
Fire Damage (Any one Fire)	\$ _____	
Medical Expense (Any one Person)	\$ _____	
Deductible Property Damage Per Claim	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> Other:	

**Schedule:**

Classification	Class Code	Premium Basis Payroll
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of Full Time Employees (Excluding Clerical / Sales People): \_\_\_\_\_

Number of Officers or Partners: \_\_\_\_\_

Total Cost of Subcontracted work for the past 12 months: \$ \_\_\_\_\_ % \_\_\_\_\_

**Additional Insured:**

**Check here if none**

1. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Interest: \_\_\_\_\_
2. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City & State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Interest: \_\_\_\_\_

\*Agent to provide Company with a copy of each Certificate of Insurance issued.

**Operation Information:**

1. Does applicant sub-contract more than 25%?      Yes      No
  2. Does applicant require that subs carry same or greater limits of liability?      Yes      No
  3. Does applicant require Certificate of Insurance for subcontracted work?      Yes      No
  4. Does applicant loan or rent equipment to others?      Yes      No
  5. Does applicant perform and/or subcontract any roofing operations?      Yes      No
  6. Any operation includes excavation, tunneling underground work or earth moving?      Yes      No
  7. Any operation includes blasting or utilizes explosive material?      Yes      No
  8. Does applicant perform or engage in any work or operation other than those listed in the classification schedule of this application?      Yes      No
- If yes, please explain: \_\_\_\_\_

**Remark:**

Prior Carrier Information:				
	Years	Years	Years	Years
Carrier				
Policy Number				
Limits				
Total Premium				

**Loss History:**

*(Enter all claims or occurrences that might rise to claims for the prior 3 years)*

Check here if none

Date of Occurrence	Type of Occurrence	Amount Paid	Claims Open	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

I agree that if my down payment or full payment check is uncollectible due to a returned check because of insufficient funds or any other form of dishonored payment including but not limited to an electronic transaction, coverage will be void or null from inception.

This application is in compliance with Florida Statute 626.752. A copy has been furnished to the applicant or insured and coverage is  
 Bound Effective 12.01 am \_\_\_\_\_ (Date) \_\_\_\_\_ (Not Bound)

On this application, Florida Statute 627.409 states: "A misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the contract or policy..."

Any person who knowingly and with intent to injure, defraud, or deceive any insurer file a statement of claim or an application containing any false, incomplete or misleading information is guilty of a **FELONY** of third degree.

I agree and understand that this application will be made part of the policy when issued.

I understand this application is not a binder indicated as such on this form by the Brokering Agent.

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date