

AGENCY NAME \_\_\_\_\_ CODE \_\_\_\_\_ POLICY NO \_\_\_\_\_

ADDRESS \_\_\_\_\_

APPLICANTS NAME \_\_\_\_\_

DBA \_\_\_\_\_

ADDRESS \_\_\_\_\_

PROPOSED EFF. DATE \_\_\_\_\_ EXP. DATE \_\_\_\_\_  QUOTE  BIND  ISSUE  
(COMPANY USE ONLY)

DEDUCTIBLE \_\_\_\_\_ RATE \_\_\_\_\_ TOTAL AMT INS \$ \_\_\_\_\_ PREMIUM \_\_\_\_\_  
 SHORT TERM  ANNUAL

CODE \_\_\_\_\_ REINS  NONE  P/R \_\_\_\_\_  EXPOSURE \_\_\_\_\_ CERT. # \_\_\_\_\_

(COMPANY USE ONLY)

DEDUCTIBLE \_\_\_\_\_ RATE \_\_\_\_\_ TOTAL AMT INS \$ \_\_\_\_\_ PREMIUM \_\_\_\_\_  
 SHORT TERM  ANNUAL

CODE \_\_\_\_\_ REINS  NONE  P/R \_\_\_\_\_  EXPOSURE \_\_\_\_\_ CERT. # \_\_\_\_\_

INDIVIDUAL  PARTNERSHIP  CORPORATION  LLC \ LLP  OTHER (specify) \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

INSPECTION  
(Contact / Phone) \_\_\_\_\_

NUMBER OF YEARS EXPERIENCE AT THIS TYPE OF WORK \_\_\_\_\_

YEARS IN BUSINESS \_\_\_\_\_

**PRIOR CARRIER INFORMATION**

YEAR	TYPE OF COVERAGE	CARRIER	POLICY NO.	PREMIUM
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**LOSS HISTORY (ENTER ALL LOSSES FOR PRIOR 5 YEARS)**

DATE OF LOSS	TYPE OF LOSS	DESCRIPTION OF LOSS	AMOUNT PAID	RESERVE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ATTACH SEPARATE SHEET OR COMPANY LOSS RUNS IF ADDITIONAL

**RED SHIELD INSURANCE COMPANY, AT ITS OPTION, WILL VERIFY RISK LOSS EXPERIENCE**

In accordance with the Fair Credit Reporting Act, Public Law 91-508, the insured is hereby advised that as part of our underwriting procedure, a routine inquiry and/or inspection may be made which will provide 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.

**Any person who knowingly or with intent to defraud any insurance company or another person files an insurance application for insurance or statement of claim containing any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.**

DATE OF APPLICATION \_\_\_\_\_

PRODUCER'S LICENSE NO. \_\_\_\_\_

SIGNATURE OF PRODUCER \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE OF APPLICANT \_\_\_\_\_

PAGE 2 MUST BE COMPLETED AND SUBMITTED WITH THIS SECTION

**APPLICANT'S NAME** \_\_\_\_\_  
(Name to which this section attaches)

**TYPE OF RISK**  **COMMERCIAL:**  NEW CONSTRUCTION  RENOVATION  **RESIDENTIAL NEW CONSTRUCTION**

**RISK LOCATION**

STREET ADDRESS \_\_\_\_\_  
CITY, COUNTY, ST., ZIP \_\_\_\_\_

**TYPE OF CONSTRUCTION**

JOISTED MASONRY BLCK, STRUCTURED STEEL WALLS & ROOF (NON-COMBUSTIBLE)  FRAME  
 CONCRETE, HOLLOW CONCRETE BLOCK, STEEL WALLS, WOOD ROOF  OTHER (Describe) \_\_\_\_\_  
 TYPE OF PROT. NUMBER BASE- YEAR TOTAL  
 ROOF CLASS STORIES MENT BUILT AREA

WILL CONSTRUCTION BE COMPLETED BY A LICENSED AND BONDED CONTRACTOR?  YES  NO (If no, attach explanation)

**TYPE OF BUILDING** (Occupancy when completed)

BUILDING #1 \_\_\_\_\_ BUILDING #2 \_\_\_\_\_  
 IF 2 OR MORE BUILDINGS, DISTANCE BETWEEN BUILDINGS \_\_\_\_\_ IF MORE THAN 2 BUILDINGS, ATTACH DIAGRAM OF PREMISES

**ESTIMATED COMPLETED VALUE**

BUILDING #1 \_\_\_\_\_ BUILDING #2 \_\_\_\_\_  
 IF RENOVATION, VALUE OF EXISTING STRUCTURE: \_\_\_\_\_  
 IF RESIDENTIAL, COMPLETE THE FOLLOWING:

ANNUAL NUMBER	DURATION	# JOBS IN PROGRESS		COST OF VALUE OF EACH INSTALLATION			MATERIAL COST (% of total)
		MAXIMUM	AVERAGE	MAXIMUM	MINIMUM	AVERAGE	
				\$	\$	\$	

**ESTIMATED TERM OF POLICY**  6 MONTHS  1 YEAR  OTHER \_\_\_\_\_

**TYPE OF SECURITY ON SITE?**

WATCHMAN  24 HOUR  NIGHT  DAY  LIGHTED  FENCED  CENTRAL ALARM

**BUILDING SPRINKLERED?**  YES  NO **EARTHQUAKE AND FLOOD REQUESTED?**  YES  NO

**ADDITIONAL INTERESTS**

NAME & ADDRESS	INTEREST
_____	LOSS PAYEE <input type="checkbox"/>
_____	ADD'L INSURED <input type="checkbox"/>
_____	LOSS PAYEE <input type="checkbox"/>
_____	ADD'L INSURED <input type="checkbox"/>
_____	LOSS PAYEE <input type="checkbox"/>
_____	ADD'L INSURED <input type="checkbox"/>
_____	LOSS PAYEE <input type="checkbox"/>
_____	ADD'L INSURED <input type="checkbox"/>

PAGE 1 MUST BE COMPLETED AND SUBMITTED WITH THIS SECTION