



RESIDENCE BASED BUSINESS SUPPLEMENT TO PERSONAL PROPERTY APPLICATIONS

DATE (MM/DD/YYYY)

PRODUCER	PHONE (A/C, No, Ext):	APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP)			
	FAX (A/C, No):				
CODE:	SUBCODE:	DBA:	E-MAIL ADDRESS:		
AGENCY CUSTOMER ID		COMPANY	ACCOUNT NUMBER		
		POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	

APPLICANT INFORMATION

<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> LIMITED CORPORATION	CODE	SIC	FEDERAL ID #	CONTACT FOR INSPECTION	PHONE (A/C, No, Ext):
<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> JOINT VENTURE					
<input type="checkbox"/> CORPORATION	<input type="checkbox"/> OTHER					

NATURE OF BUSINESS

<input type="checkbox"/> OFFICE SERVICE	<input type="checkbox"/> RETAIL WHOLESALE	<input type="checkbox"/> CRAFTS	YRS IN BUS	CLASS CODE	LIST NAMES OF OWNERS/OPERATORS	
# OF EMPLOYEES FULL TIME	# OF EMPLOYEES PART TIME	HOURS OF OPERATION	SQ FT USED	ANNUAL SALES/RECEIPTS	TOTAL PAYROLL	
				\$	\$	
DESCRIPTION OF BUSINESS						

PROPERTY COVERAGES

COVERAGE	PERSONAL PROPERTY LIMITS W/O BUSINESS PROPERTY	PERSONAL PROPERTY LIMITS WITH BUSINESS PROPERTY	BUSINESS RELATED STRUCTURE		
LIMITS	\$	\$	\$		
VALUATION	\$	\$	\$		

LIABILITY COVERAGES (Choose the limit options compatible with the program you are requesting)

COMBINED SINGLE LIMIT	\$	\$	HIRED AUTO	\$
BODILY INJURY & PROP DAMAGE	OCCURRENCE \$	PRODUCTS/ COMPL. OPERATIONS	OCCURRENCE \$	NON-OWNED AUTO \$
	AGGREGATE \$		AGGREGATE \$	EMPLOYEE BENEFITS \$
MEDICAL EXPENSE (PER PERSON)	\$		\$	\$
DAMAGE TO RENTED PREMISES	\$		\$	\$
DEDUCTIBLE	\$	%	APPLICABLE TO:	

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. ANY BUSINESS CONDUCTED AT ANY OTHER LOCATION?			8. ANY PRODUCTS DIRECTLY IMPORTED OR EXPORTED OUTSIDE THE U.S., PUERTO RICO OR CANADA?		
2. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?			9. ANY PRODUCTS REPACKAGED, MODIFIED OR MIXED?		
3. ANY WORKERS COMPENSATION CARRIED?			10. ANY USED ITEMS SOLD?		
4. DO YOU RENT OR LOAN EQUIPMENT TO OTHERS?			11. IF THE BUSINESS IS AN OFFICE, THE NUMBER OF VISITORS PER WEEK IS: UNDER 10 <input type="checkbox"/> 10 OR MORE <input type="checkbox"/>		
5. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY OR DOES THE APPLICANT HAVE ANY SUBSIDIARIES?			12. DO YOU DISTRIBUTE YOUR PRODUCTS OR SERVICES BY MEANS OF THE INTERNET?		
6. DOES THE BUSINESS INVOLVE THE USE OR STORAGE OF PETROLEUM-BASED PRODUCTS, PAINT, FERTILIZER, PESTICIDES OR OTHER HAZARDOUS MATERIAL OR POLLUTANTS?			13. DOES YOUR COMPANY MAINTAIN OR SUPPORT AN INTERNET WEBSITE?		
7. HAS ANY APPLICANT FILED FOR BANKRUPTCY (BUSINESS OR PERSONAL) IN THE LAST FIVE YEARS?			14. DOES THE BUSINESS INVOLVE DEMONSTRATION OF ANY PRODUCTS?		

PRIOR POLICY(IES)/BUSINESS LOSS HISTORY

See attached loss summary

PREVIOUS CARRIER	POLICY NUMBER	TOTAL PREMIUM	EXP DATE	# BUSINESS LOSSES LAST 3 YEARS	TOTAL LOSSES
					\$
DESCRIPTION OF BUSINESS LOSSES, WHETHER OR NOT INSURED (Date, cause, amt paid, claim status). USE ADDITIONAL SHEET IF NECESSARY.					

ADDITIONAL INTEREST

INTEREST	NAME AND ADDRESS	REFERENCE #:	CERTIFICATE REQUIRED	REMARKS
<input type="checkbox"/> ADDITIONAL INSURED				
<input type="checkbox"/> LOSS PAYEE				
<input type="checkbox"/> LIENHOLDER				
<input type="checkbox"/> EMPLOYEE AS LESSOR				
	ITEM DESCRIPTION:			