CAMICO

BUSINESS OWNERS PACKAGE INSURANCE APPLICATION

Program available through:
CAMICO Insurance Services
Tel: 800.652.1772

Part 1: General Information

1. Firm Name: _____

2. Contact Person: _____
   (Person designated and authorized by the Firm to receive any and all notices concerning this insurance.)

3. Contact Person Title: _____ 4. Contact Person E-mail: _____

5. Primary Mailing Address: _____
   Mailing Address City State Zip

6. Telephone: _____ 7. Fax: _____

8. Entity Type: ❒ Sole Proprietorship ❒ Partnership / LLP ❒ Corporation ❒ LLC ❒ PC ❒ Other (list): _____
   (If partnership, please provide a list of all partners on a separate sheet)

9. Year Established (yyyy): _____ 10. Web Site: _____

11. Do you have more than 50% ownership interest in any other business? ❒ Yes ❒ No
    If "Yes", please list: _____

Part 2: Coverage Options

❒ **Business Owners Package – Property & Liability – Complete Part 3 (below)**
❒ **Business Umbrella (optional) – Complete Part 5 (page 2)**

Part 3: Business Owners Package Coverage – Property & Liability

12. Effective Date: _____

13. Number of office locations: _____
    Please complete the attached Additional Location Supplement for each additional location (Page 4.)

14. Primary Building Address: (If different from #5)

    _____
    Street Address City County State Zip

15. Building value: $_____ (if owner)

16. Business personal property (*contents) value: $_____
    * Office furniture, copiers, facsimile machines, etc.

17. Tenants improvements & betterments value: $_____
    (Installed fixtures, e.g. cubicles, kitchen etc.)

18. Computers & media value: $ _____

19. Construction Type: ❒ Frame ❒ Joisted masonry ❒ Non-combustible
    ❒ Masonry, non-combustible ❒ Fire resistive

20. Year Built: _____

21. Fully sprinklered? ❒ Yes ❒ No

22. Area occupied at this location (sq.ft.): _____

23. Annual revenue at this location: $ _____

24. Number of stories: _____

25. Number of property or liability losses in last 3 years: _____
    If there have been any losses please complete the attached Property Loss History Supplement (Page 5) and loss runs on a separate sheet of paper.

Part 4: Basic Coverage Requested

26. Liability Limit: ❒ $1,000,000 per occurrence / $2,000,000 aggregate
❒ $2,000,000 per occurrence / $4,000,000 aggregate

27. Fire Legal Limit: ❒ $300,000 *(minimum)* ❒ $500,000 ❒ $1,000,000

28. Property Deductible: ❒ $500 ❒ $1000 ❒ $2500 ❒ $5000

29. Do you currently have a Business Auto Policy? ❒ Yes ❒ No
If, "Yes," please complete the attached Business Owned Auto Supplement (Page 5).

30. Do any of your employees regularly (more than 3 times per week) use their personal autos as part of their job requirements? ❒ Yes ❒ No
If "Yes," please complete the attached Hired Non-Owned Auto Supplement (Page 5).

Part 5: Business Umbrella (optional)

31. Umbrella coverage in addition to the primary liability limits:
❒ $1,000,000 ❒ $2,000,000 ❒ $3,000,000 ❒ $4,000,000 ❒ $5,000,000

Part 6: Prior Carrier Information

32. Have you had any prior business owners insurance in the last 4 years? ❒ Yes ❒ No
If "Yes," please list carriers, policy numbers, expiration dates, premium if available.

Carrier	Policy Number	Expiration Date	Premium

Part 7: Business Owned Auto Supplement (optional for Corp. & L.L.C. Entities)

33. If you have a business auto policy, what is your effective date? _____

34. If you have business owned vehicles, please list all drivers:

Name	License Number	State	DOB

35. Please list any vehicles registered to your business:

Vehicle	VIN	Year	Make	Model	Body Type
a					
b					

Vehicle	Garage Zip	Radius (Truck)	GVW (Truck)	Cost New	Comp. Ded	Coll Ded
a						
b						

36. Number of business owned auto losses in last 3 years: _____
If any losses, please complete the attached Business-Owned Auto Loss Supplement (Page 5).

Part 8: Signatures

The undersigned proprietor, authorized partner of the partnership, or authorized stockholder of the corporation represents that the following statements are understood and agreed to by the applicant:

By signing this application, the undersigned represents that he or she has made inquiries of all Firm members as appropriate and that all Firm members are bound by the representations made on this application, any supplemental application, and any supplemental data and documents provided.

Signing this application or tendering premium does not bind the applicant or the company to issue insurance coverage, but it is agreed that this application shall be the basis of the contract should a policy be produced.

Name: (Please Print) _____

Signature: _____ Date: _____

Position/Title: _____

Applicant/Firm: _____

Please send completed application and appropriate supplemental forms to:

Sales Department
CAMICO Insurance Services
1800 Gateway Drive, Suite 300
San Mateo, CA 94404

Call: **1.800.652.1772**
E-mail: **info@camicosolutions.com**
Fax: **1.800.496.9910**

WARNING – Residents of Arizona, Arkansas, Colorado, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maine, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Virginia, Washington and West Virginia

Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution and imprisonment. (For Arizona, Florida, Georgia, North Carolina, and Oregon residents only: All statements and descriptions in this application for insurance and in any negotiations therefore, by or behalf of the insured, shall be deemed to be representations and not warranties. For CO residents only: Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.)

Additional Location Supplement

1. Office location 2:

_____
Street Address City County State Zip

2. Building value: $_____ (if owner)
3. Business personal property (*contents) value: $_____
* Office furniture, copiers, facsimile machines, etc.
4. Tenants improvements & betterments value: $_____
(Installed fixtures, e.g. cubicles, kitchen etc.)
5. Computers & media value: $ _____
6. Construction Type: ❒ Frame ❒ Joisted masonry ❒ Non-combustible
❒ Masonry, non-combustible ❒ Fire resistive
7. Year Built: _____
8. Fully sprinklered? ❒ Yes ❒ No
9. Area occupied at this location (sq.ft.): _____
10. Annual revenue at this location: $ _____
11. Number of stories (if owned): _____

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1. Office location 3:

_____
Street Address City County State Zip

2. Building value: $_____ (if owner)
3. Business personal property (*contents) value: $_____
* Office furniture, copiers, facsimile machines, etc.
4. Tenants improvements & betterments value: $_____
(Installed fixtures, e.g. cubicles, kitchen etc.)
5. Computers & media value: $ _____
6. Construction Type: ❒ Frame ❒ Joisted masonry ❒ Non-combustible
❒ Masonry, non-combustible ❒ Fire resistive
7. Year Built: _____
8. Fully sprinklered? ❒ Yes ❒ No
9. Area occupied at this location (sq.ft.): _____
10. Annual revenue at this location: $ _____
11. Number of stories: _____

Property Loss History Supplement

1. Please complete for any losses in the last 3 years. Attach loss runs or describe below if not available.

Date of Loss	Description	Loss Amount

Business Owned Automobile Supplement

1. Please complete for any losses in the last 3 years. Attach loss runs or describe below if not available.

Vehicle	Date of Loss	Drive Name	At Fault (y/n)	Incurred Amount
a				
b				

Vehicle	Liability	Uninsured Motorist	Physical Damage	Description
a				
b				

Hired/Non-owned Automobile Insurance-Drivers Information Supplement

1. Include all accountants and any employees, in the course of their business day who drive their own vehicles for business utilized more than 3 times a week.

Name	Drivers License #	State Licensed

