

1 Airport Plaza • PO Box 51019  
 Idaho Falls ID 83405-1019  
 (208) 522-5656 • (800) 243-6344  
 FAX 524-5721



1220 Cleveland Blvd. • PO Box 400  
 Caldwell ID 83606-0400  
 (208) 459-1678 • (800) 828-7835  
 FAX 454-1114

## General Commercial Application

We appreciate the opportunity in providing your company with its insurance needs. The purpose of this questionnaire is to assist us, and the designated insurance company, in evaluating your business.

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### BACKGROUND

Name of Business: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ State of Incorporation: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Website: \_\_\_\_\_

Type of Business Entity:  Corporation  LLC  Partnership  
 Individual  Joint Venture  Other: \_\_\_\_\_

Federal Employer I.D. Number: \_\_\_\_\_ Fiscal year end: \_\_\_\_\_

Year company started: \_\_\_\_\_ Year current management started: \_\_\_\_\_

Annual Gross Receipts: \_\_\_\_\_ Annual Payroll: \_\_\_\_\_

Geographic area of operation: \_\_\_\_\_

Describe your operations: \_\_\_\_\_

#### Ownership:

Name	Title	Percent of Business Owned

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**Location(s)** (information needed for each location/building, print additional pages as needed)

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you the:  Owner  Tenant

No. of Buildings at this Location: \_\_\_\_\_ Value of Building: \_\_\_\_\_ Value of Contents: \_\_\_\_\_

Describe operations at this location: \_\_\_\_\_

Year Built: \_\_\_\_\_ Type of Construction: \_\_\_\_\_

Roof Type: \_\_\_\_\_ No. of Stories: \_\_\_\_\_

Total Square Feet: \_\_\_\_\_ Square Feet you Occupy: \_\_\_\_\_

Any Other Occupants in the Building: \_\_\_\_\_

When were the following systems updated? (Required if the building is over 25 years old)

Electrical: \_\_\_\_\_ Plumbing: \_\_\_\_\_ Roof: \_\_\_\_\_ Heating: \_\_\_\_\_

Fire Protection:

 Smoke Detectors  Pull Alarms  Central Station Alarm  Sprinklers

Burglar Protection:

 Local Alarm  Central Station Alarm  Onsite Security  Roving Security

Mortgages or Loss Payees:

Name of Company: \_\_\_\_\_

Address: \_\_\_\_\_

Loan or Account No: \_\_\_\_\_

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**Desired Commercial Liability Limits:**

Per Occurrence Liability Limit: \_\_\_\_\_

General Aggregate Liability  
Limit: \_\_\_\_\_

Fire Damage Legal Limit: \_\_\_\_\_

Medical Expense Limit: \_\_\_\_\_

Employee Benefits Liability  
Limit: \_\_\_\_\_

Please list any Additional Insureds you would like on the policy (Landlord, etc.):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Interest: \_\_\_\_\_

Do you need an Umbrella Policy?  Yes  No If yes, what limit? \_\_\_\_\_Do you need Professional Liability?  Yes  No If yes, what limit? \_\_\_\_\_

**Desired Business Automobile Coverage:**

Bodily Injury / Property Damage Limit:  1,000,000  Other: \_\_\_\_\_

Medical Payment Limit:  5,000  Other: \_\_\_\_\_

Do you need Hired Auto Physical Damage?  Yes  No

Do any employees use their vehicles on a regular basis for the company?  Yes  No

Number of employees: \_\_\_\_\_

Driver List:

Drivers Name	License Number	Date of Birth	State Licensed In:

Vehicle List: (must be titled in the name of the insured on the policy)

Year	Make	Model	Vin Number	Cost New / Stated Value if Physical Damage is Desired

Comprehensive Deductible:  250  500  1,000  Other \_\_\_\_\_

Collision Deductible:  250  500  1,000  Other \_\_\_\_\_

**Workers Compensation:**

Classification	No. of Employees	Estimated Annual Payroll

Officers	Duties	Percent Owned	Included or Excluded

## Equipment Schedule:

Year	Make	Model	Serial Number	Value

Do you rent any equipment?  Yes  No

If Yes what is your estimated annual rental expense? \_\_\_\_\_

## Current Insurance Information:

Insurance Carrier: \_\_\_\_\_

Agents or Brokers Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Premium: \_\_\_\_\_

Term From: \_\_\_\_\_ To: \_\_\_\_\_

## Prior Loss Information:

Has your business had any known losses in the past five years?  Yes  No

Loss Date	What Happened	Amount Paid to Date

Please attached or request three years of currently valued loss information from your current insurance provider.

Company Name: \_\_\_\_\_

By: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_