Quote Request Form

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Application Information **Effective Date Requested**: _____

Business Name and dba: _____

***Federal ID #:** _____ Email: _____ Phone #: _____ Fax #: _____

Business Type: ☐ Corp. ☐ LLC ☐ Ltd ☐ Partnership ☐ Individual ☐ Other: _____

Address _____ City _____ State _____ Zip _____

Detailed Description of Operations: _____

***Current Carrier** _____ Policy Period: _____ Years in business: _____

Limits and Benefits: _____ ***Annual Premium**: _____

Does applicant currently have a Safety/Loss Control Program implemented? ☐ Yes ☐ No Date started _____

If **yes**, please provide the Name of company providing service: _____

Please attach or describe safety program: _____

***Rating Information**

***Officers/Owners:** ☐ **Included** ☐ **Excluded**

NCCI/WC Code	WC Classification Description	Number of Employees Full Time	Number of Employees Part Time	Any 1099s	Gross Monthly Payroll
8809	Executive Officers				
8810	Clerical				

***Loss information** Note: Legible hard copy Loss Runs must be attached to quote inclusive of description where necessary

Please provide total loss information (minimum last three years, if insured, with a description of all losses in excess of $5,000)

Policy Period	Insurer Carrier / Product (loss runs cannot be over 60 days old)	Paid Losses Medical	Paid Losses Losses	Outstanding Medical	Outstanding Indemnity	No. of Losses

1) Is your operation a Contained facility? ☐ Yes ☐ No If **No**, describe offsite installation and or repair.

2) Does your company have any Warehouse Exposure? ☐ Yes ☐ No

Average weight of product or package stored: _____ Lbs. Forklifts used? (#) _____

Loading/Unloading _____ % Describe: _____

3) Does your company have any height exposure over 1 story? ☐ Yes ☐ No

If Yes, please describe in detail and identify maximum height: _____

4) What are the company's hours of operation for each location: _____

5) Indicate the number of vehicles the applicant owns, leases or operates by radius and type.

Radius of Operation	Private Passenger	Number of Commercial Units: Light	Medium	Heavy	X-Heavy	Tractors
0-50						
51-200						
Over 200						
Other						

* Is applicant subject to LPG or TxDOT Regulations? ☐ Yes ☐ No

*** Required Field**

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6) Are employees required to drive their own vehicles for business purposes? ☐ Yes ☐ No
If <u>yes</u>, please provide number and details of use: _____

7) Do you run MVR's on above? ☐ Yes ☐ No Please provide **<u>minimum</u>** acceptance criteria. Attach separate sheet if needed.

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8) Does the applicant manufacture, store, distribute, sell, handle or transport any of the following?

Chemicals	☐ Yes ☐ No	Details:	_____
Pharmaceuticals	☐ Yes ☐ No	Details:	_____
Explosives	☐ Yes ☐ No	Details:	_____
Gasoline	☐ Yes ☐ No	Details:	_____
Fuel Oils	☐ Yes ☐ No	Details:	_____
Hazardous Wastes	☐ Yes ☐ No	Details:	_____
Nuclear Materials	☐ Yes ☐ No	Details:	_____
Asbestos Materials	☐ Yes ☐ No	Details:	_____

9) Describe any past Employers Liability, Occupational Disease, Cumulative Trauma or workplace negligence claims Employees have brought against your company.

Terms and Coverage Limits Available

Deductible	Coverage Period (weeks)	Coverage A (AD&D, Med, DI&OD/CT)	Coverage B (Employers Liability)
☐ $1,000	☐ **104 Weeks**	☐ $100,000	☐ $100,000
☐ $2,500	☐ **156 Weeks**	☐ $150,000	☐ $150,000
☐ $5,000		☐ $200,000	☐ $200,000
☐ $10,000		☐ $250,000	☐ $250,000
☐ $25,000		☐ $300,000	☐ $300,000
☐ $50,000		☐ $500,000	☐ $500,000
7 day DI elimination period		☐ $1,000,000	☐ $1,000,000
Per Occurrence Aggregate is set at			

	Quote Req. 1	Quote Req. 2
Deductible		
Coverage Period		
Coverage A		
Coverage B		

Return quote(s) to:
Agent Name: _____ Agency Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
E-Mail Address: _____ Web Site: _____

To the best of my knowledge, the information given is accurate and factual. I understand that this form does not bind any agent. or Administrator to coverage. This is a Quotation Request Form and will not effect any insurance until approved in writing from Dittrich & Associates or any other Insurance Company.

Signed: _____ Dated: _____