

Commercial New Business Information Worksheet

Effective Date: _____ Producer Name: _____ Producer Phone #: _____

Named Insured (Include D/B/A): _____

Entity: Sole Proprietor _____ Partnership _____ Corporation _____ LLC _____

Mailing Address: _____ City _____ State: _____ Zip: _____

Contact Name: _____ Phone: (____) _____ Fax: (____) _____

E-Mail/Website Information: _____ Date Est.: _____

Description Of Operations: _____ Yrs. Of Exp. _____

Location	Location Address	Owner/Tenant
1.		
2.		

Premises Information:

Loc.#	Construction Type	Year Built	# Of Stories	Total Sq. Ft	Sq. Ft Occupied	Sprinkler Y/N	Alarm System	Other Occupants
1.								
2.								

Building Updates Year: Heating _____ Plumbing _____ Electrical _____ Roof _____ Property _____

Information:

Coverage:	Limit:	Deductible:	Co Insurance:
Building			
Business Personal Property			
Property of Others			
Inland Marine			
Business Income			

Liability Information:

Coverage:	Limit:	Gross Sales:	Gross Payroll:
General Liability			
Umbrella		XXXXXXXXXXXXXXXXXXXXX	

Subcontracting:

Does Insured Subcontract _____ Yes _____ No _____ If yes, what % is subcontracted out? _____%

Commercial New Business Information Worksheet – Continued

Producer Name: _____ Producer Phone#: _____
 Hired & Non-Owned Auto Coverage: Yes ___ No ___
 Workers' Comp Information – Federal ID # _____ Experience Mod: _____
 Limits: \$100,000/\$500,000/\$100,000 - \$500,000/\$500,000/\$500,000 - \$1,000,000/\$1,000,000/\$1,000,000

State	Class Code	Description of Classification	# of Employees	Payroll

Workers' Comp Owners/Officer's Coverage

Exclude

Name:	Title:	Class:	Payroll	Yes	No

Rockford Mutual only (credit check required)

Owner name: _____

Owner DOB: _____

Social Security/FEIN No. _____

Prior Carrier Info: Company: _____ Premium: _____ Term: _____
 _____ Any Claims in the past 3 years: No _____ If yes, send in loss runs

Automobile / Driver Supplement

Current Policy Information:

Auto Coverage:	Symbol(s)	Covered Auto Symbols
Liability Limit: \$		(1) Any Auto (2) All owned Autos
Medical Limit: \$		(3) Owned Private Passenger Autos (4) Owned Autos Other than PPT
UM/UIM Limit \$		(5) All owned Autos Requiring No Fault Coverage
Comprehensive Deductible: \$		(6) Owned Autos Subject to compulsory U.M. Law (7) Autos Specified on Schedule
Collision Deductible: \$		(8) Hired Autos (9) Non-Owned Auto

Additional Coverages:

Drive Other Car Coverage: Names:	Towing: (available only on PPT)
Rental reimbursement Coverage: (available only on PPT)	Hired Physical Damage: Limit:

Vehicle Description:

Veh. #	Yr.	Make/Model	Serial #	Cost New	Garage Location
1.					

Driver Schedule:

Name:	Date of Birth:	State:	License #:

Additional vehicles and drivers continued on next page

Vehicle Description:

Veh. #	Yr.	Make/Model	Serial #	Cost New	Garage Location
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
13.					

Driver Schedule:

Name:	Date of Birth:	State:	License #:

Additional Notes Page: