



AGENCY CUSTOMER ID: _____

UMBRELLA / EXCESS SECTION

DATE (MM/DD/YYYY)

AGENCY				APPLICANT (First Named Insured)			
POLICY NUMBER				CARRIER		NAIC CODE	
EFFECTIVE DATE	EXPIRATION DATE	☐ DIRECT BILL ☐ AGENCY BILL	PAYMENT PLAN		AUDIT	FOR COMPANY USE ONLY	

POLICY INFORMATION

TRANSACTION TYPE				LIMIT OF LIABILITY		RETAINED LIMIT	
☐ NEW	☐ UMBRELLA	☐ OCCURRENCE	RETROACTIVE DATE		\$ EA OCC	\$	
☐ RENEWAL	☐ EXCESS	☐ CLAIMS MADE	☐ PROPOSED	☐ CURRENT			
EXPIRING POL #:					\$	FIRST DOLLAR DEFENSE (Y/N)	

EMPLOYEE BENEFITS LIABILITY

LIMIT OF INSURANCE (Ea Employee)	AGGREGATE LIMIT FOR EBL	RETAINED LIMIT FOR EBL	RETROACTIVE DATE FOR EBL
\$	\$	\$	
NAME OF BENEFIT PROGRAM			

PRIMARY LOCATION & SUBSIDIARIES (ACORD 125)

#	NAME AND LOCATION OF PRIMARY AND ALL SUBSIDIARY COMPANIES (Describe Operations)	ANNUAL PAYROLL	ANN GROSS SALES	FOREIGN GROSS SALES	# EMPL
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				

UNDERLYING INSURANCE

LIST ALL LIABILITY/COMPENSATION POLICIES IN FORCE TO APPLY AS UNDERLYING INSURANCE						+ - RATING MOD
TYPE	CARRIER/POLICY NUMBER	POLICY EFF DATE	POLICY EXP DATE	LIMITS	ANNUAL RENEWAL PREMIUM	
AUTOMOBILE LIABILITY				CSL EA. ACC. \$	\$	
				BI EA. ACC. \$	\$	
				BI EA. PER. \$	\$	
				PD EA. ACC. \$	\$	
GENERAL LIABILITY POLICY TYPE ☐ OCCUR ☐ CLAIMS MADE				EACH OCCURRENCE \$	PREM/OPS	
				GENERAL AGGR \$	\$	
				PROD & COMP OPS AGGREGATE \$	PRODUCTS	
				PERSONAL & ADV INJURY \$	\$	
				DAMAGE TO RENTED PREMISES \$	OTHER	
				MEDICAL EXPENSE \$	\$	
EMPLOYERS LIABILITY				EACH ACCIDENT \$	\$	
				DISEASE		
				EACH EMPLOYEE \$		
				DISEASE POLICY LIMIT \$		

ATTACH TO ACORD 125 AND ACORD 126

UNDERLYING INSURANCE (continued)

UNDERLYING GENERAL LIABILITY INFORMATION (Explain all "YES" responses)											
1. ARE DEFENSE COSTS:		WITHIN AGGREGATE LIMITS?		A SEPARATE LIMIT?		UNLIMITED?					
2. INDICATE THE EDITION DATE OF THE ISO FORM OR SIMILAR FILING FOR THE UNDERLYING COVERAGE:											
3. HAS ANY PRODUCT, WORK, ACCIDENT, OR LOCATION BEEN EXCLUDED, UNINSURED OR SELF INSURED FROM ANY PREVIOUS COVERAGE? (Y/N) ☐											
4. FOR CLAIMS MADE, INDICATE RETROACTIVE DATE OF CURRENT UNDERLYING POLICY:											
5. FOR CLAIMS MADE, INDICATE ENTRY DATE INTO UNINTERRUPTED CLAIMS MADE COVERAGE:											
6. FOR CLAIMS MADE, WAS "TAIL" COVERAGE PURCHASED FOR ANY PREVIOUS PRIMARY OR EXCESS POLICY? (Y/N) ☐ EFF. DATE: _____											
CHECK ALL COVERAGES IN UNDERLYING POLICIES. ALSO CHECK IF ANY EXPOSURES ARE PRESENT FOR EACH COVERAGE. PROVIDE AN EXPLANATION. EXPLAIN IF DIFFERENT LIMITS, EXTENSIONS, OR EXCLUSIONS. EXPLAIN ANY SPECIAL COVERAGES BEYOND STANDARD FORMS. EXPLAIN ALL EXPOSURES.											
CHECK IF APPROPRIATE			COVERAGE		EXPOSURE		COVERAGE			EXPOSURE	
☐	ANY AUTO (SYMBOL 1)		☐	CARE, CUSTODY, CONTROL	☐	☐	☐	PROFESSIONAL LIABILITY (E&O)		☐	☐
☐	CGL - CLAIMS MADE		☐	EMPLOYEE BENEFIT LIABILITY	☐	☐	☐	VENDORS LIABILITY		☐	☐
☐	CGL - OCCURRENCE		☐	FOREIGN LIABILITY/TRAVEL	☐	☐	☐	WATERCRAFT LIABILITY		☐	☐
COVERAGE			EXPOSURE		☐	☐	☐			☐	☐
☐	AIRCRAFT LIABILITY		☐	GARAGEKEEPERS LIABILITY	☐	☐	☐			☐	☐
☐	AIRCRAFT PASSENGER LIABILITY		☐	INCIDENTAL MEDICAL MALPRACTICE	☐	☐	☐			☐	☐
☐	ADDITIONAL INTERESTS		☐	LIQUOR LIABILITY	☐	☐	☐			☐	☐
☐			☐	POLLUTION LIABILITY	☐	☐	☐			☐	☐
UNDERLYING INSURANCE COVERAGE INFORMATION (INCLUDE ALL RESTRICTIONS; E.G. LASER ENDORSEMENTS, DISCRIMINATION, SUBROGATION WAIVERS, OR EXTENSIONS OF COVERAGE - ATTACH SEPARATE SHEET IF NECESSARY)											
PREVIOUS EXPERIENCE: (GIVE DETAILS OF ALL LIABILITY CLAIMS EXCEEDING \$10,000 OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS, DURING THE PAST 5 YEARS, WHETHER INSURED OR NOT. SPECIFY DATE, COVERAGE, DESCRIPTION, AMOUNT PAID, AMOUNT OUTSTANDING - ATTACH SEPARATE SHEET IF NECESSARY)											
☐ NO SUCH CLAIMS											

CARE, CUSTODY, CONTROL

LOC	PROPERTY TYPE	VALUE	A*	B*	C*	D*	SQ FT OF BLDG OCC
	REAL						
	PERSONAL						
OCCUPANCY / DESCRIPTION OF PERSONAL PROPERTY							
*APPLICANT: [A] IS HELD HARMLESS IN THE LEASE, [B] HAS A WAIVER OF SUBROGATION, [C] IS A NAMED INSURED IN THE FIRE POLICY, [D] OTHER (specify)							

VEHICLES

TYPE		# OWNED	# NON-OWNED	# LEASED	PROPERTY HAULED	0-50 MI	50-200 MI	OVER 200 MI
PRIVATE PASSENGER								
TRUCKS	LIGHT							
	MEDIUM							
	HEAVY							
	EX. HEAVY							
TRUCKS/TRACTORS	HEAVY							
	EX. HEAVY							
BUSES								

ADDITIONAL EXPOSURES

EXPLAIN ALL "YES" RESPONSES, PROVIDE OTHER INFORMATION REQUIRED		Y/N
ADVERTISERS LIABILITY		
1. MEDIA USED: ANNUAL COST: \$		
2. ARE SERVICES OF AN ADVERTISING AGENCY USED?		☐
3. ANY COVERAGE PROVIDED UNDER AGENCY'S POLICY?		☐
AIRCRAFT LIABILITY		
4. DOES APPLICANT OWN/LEASE/OPERATE AIRCRAFT?		☐
AUTO LIABILITY		
5. ARE EXPLOSIVES, CAUSTICS, FLAMMABLES OR OTHER DANGEROUS CARGO HAULED?		☐
6. ARE PASSENGERS CARRIED FOR A FEE?		☐
7. ANY UNITS NOT INSURED BY UNDERLYING POLICIES?		☐
8. ARE ANY VEHICLES LEASED OR RENTED TO OTHERS?		☐
9. ARE HIRED AND NON/OWNED COVERAGES PROVIDED?		☐
CONTRACTORS LIABILITY		
10. IS BRIDGE, DAM, OR MARINE WORK PERFORMED?		☐
11. DESCRIBE TYPICAL JOBS PERFORMED (Attach additional sheets if more space is required)		
12. DESCRIBE AGREEMENT (Attach additional sheets if more space is required)		
13. DOES APPLICANT OWN, RENT, OR OTHERWISE USE CRANES?		☐
14. DO SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN APPLICANT?		☐
EMPLOYERS LIABILITY		
15. IS APPLICANT SELF-INSURED IN ANY STATE?		☐
16. SUBJECT TO: ☐ JONES ACT ☐ FELA ☐ STOP GAP ☐ OTHER:		
INCIDENTAL MALPRACTICE LIABILITY		
17. IS A HOSPITAL OR FIRST AID FACILITY MAINTAINED?		☐
18. ARE COVERAGES PROVIDED FOR DOCTORS / NURSES?		☐
19. INDICATE # OF DOCTORS: _____ NURSES: _____ BEDS: _____		

AGENCY CUSTOMER ID: _____

REMARKS (Attach additional sheets if more space is required)

REMARKS

AGENCY CUSTOMER ID: _____

SIGNATURE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR or VT; in DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)

IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IF THE COMPANY TO WHICH I AM APPLYING OFFERS UNINSURED MOTORISTS (UM) AND/OR UNDERINSURED MOTORISTS (UIM) COVERAGE IN MY STATE:

UNINSURED MOTORISTS (UM) COVERAGE: \$ _____ * UNDERINSURED MOTORISTS (UIM) COVERAGE: \$ _____ *

* IF APPLICABLE IN YOUR STATE

APPLICABLE ONLY IN GEORGIA, LOUISIANA, NEW HAMPSHIRE, VERMONT AND WISCONSIN

APPLICABLE ONLY IN GEORGIA AND LOUISIANA:

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS, UM LIMITS LOWER THAN MY LIABILITY LIMITS, OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. OR 2. I REJECT UM COVERAGE IN ITS ENTIRETY.
(INITIALS) (INITIALS)

APPLICABLE ONLY IN NEW HAMPSHIRE:

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION. OR 2. I REJECT UM COVERAGE IN ITS ENTIRETY.
(INITIALS) (INITIALS)

APPLICABLE ONLY IN VERMONT:

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED UM COVERAGE EQUAL TO MY LIABILITY LIMITS. I HAVE SELECTED THE LIMITS INDICATED IN THIS APPLICATION.

APPLICABLE ONLY IN WISCONSIN:

UM COVERAGE: ☐ IS AVAILABLE ☐ IS NOT AVAILABLE UIM COVERAGE: ☐ IS AVAILABLE ☐ IS NOT AVAILABLE

IMPORTANT - THE STATEMENTS (ANSWERS) GIVEN ABOVE ARE TRUE AND ACCURATE. THE APPLICANT HAS NOT WILLFULLY CONCEALED OR MISREPRESENTED ANY MATERIAL FACT OR CIRCUMSTANCE CONCERNING THIS APPLICATION. THIS APPLICATION DOES NOT CONSTITUTE A BINDER.

APPLICANT'S SIGNATURE

DATE