



BROKERING AGENT'S REGISTER NUMBER # _____

Program Insurance Application

| | | | | | |
|----------------------------------|--|---------------------|----------------|------------------------|---------------------|
| CARRIER: GRANADA INS. CO. | | UNDERWRITER: | | DATE: | |
| PRODUCER: | | | DATE BOUND: | | TIME BOUND: |
| ADDRESS: | | | POLICY NUMBER: | | |
| | | | EFF DATE: | | EXP DATE: |
| PHONE: | | | PREMIUM: | | POLICY FEE: \$25.00 |
| PRODUCER CODE: | | PRODUCER ID: | | TOTAL PREMIUM : | |

APPLICANT INFORMATION

| | | | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|-------------------------------|--------------------|------|
| NAMED INSURED: | | | | | |
| MAILING ADDRESS: | | | | | |
| CITY: | | COUNTY: | | STATE: | ZIP: |
| INDIVIDUAL <input type="checkbox"/> | PARTNERSHIP <input type="checkbox"/> | CORPORATION <input type="checkbox"/> | LLC: <input type="checkbox"/> | YEARS IN BUSINESS: | |
| INSPECTION CONTACT: | | | ACCOUNTING RECORD CONTACT: | | |
| PHONE: | | | PHONE: | | |

PREMISES INFORMATION

| | | | | | |
|-----------|---------|-------|---------|-----------|------|
| LOC # 1 : | STREET: | CITY: | COUNTY: | STATE: FL | ZIP: |
| LOC # 2 : | STREET: | CITY: | COUNTY: | STATE: FL | ZIP: |

| |
|--------------------------------|
| BUSINESS INFORMATION |
| BUSINESS OF INSURED (DESCRIBE) |

COMERCIAL GENERAL LIABILITY - OCCURRENCE FORM

CGL Property Damage Deductible \$500

| COVERAGE | LIMITS | |
|---|--------|--|
| EACH OCCURRENCE/AGGREGATE C S L | \$ | |
| PRODUCTS / COMPLETE OPERATION AGGREGATE | \$ | RATING AND PREMIUM BASIS (P) PAYROLL - PER \$1,000 (S) SALES - PER \$1,000 |
| PERSONAL AND ADVERTISING INJURY | \$ | |
| FIRE DAMAGE (ANY ONE FIRE) | \$ | ← MAX LIMIT AVAILABLE \$50,000 |
| MEDICAL EXPENSE (ANY ONE PERSON) | \$ | ← MAX LIMIT AVAILABLE \$1,000/10,000 |

SCHEDULE

| CLASSIFICATION | CLASS CODE | PREMIUM BASIS P - S |
|--|------------|---------------------|
| | | |
| | | |
| | | |
| | | |
| NUMBER OF FULL TIME EMPLOYEES EXCLUDING CLERICAL / SALES PEOPLE: # | | |
| NUMBER OF OFFICERS OR PARTNERS: | | |
| TOTAL COST OF SUBCONTRACTED WORK FOR THE PAST 12 MONTHS: \$ | | |

ADDITIONAL INSURED Explain Interest

| | |
|----------|-------------------|
| NAME: | SPECIFY INTEREST: |
| ADDRESS: | |
| NAME: | SPECIFY INTEREST: |
| ADDRESS: | |

Agent to provide company with a copy of each certificate of insurance issued

| OPERATION INFORMATION | YES | NO |
|--|-----|----|
| DOES APPLICANT REQUIRE CERTIFICATES OF INSURANCE FOR SUBCONTRACTED WORK? | | |
| DOES APPLICANT PERFORM ANY DEMOLITION WORK? | | |
| DOES APPLICANT LOAN OR RENT EQUIPMENT TO OTHERS? | | |
| DOES APPLICANT PERFORM AND/OR SUBCONTRACT ANY ROOFING WORK | | |
| ANY OPERATIONS INCLUDE EXCAVATION, TUNNELING UNDERGROUND WORK OR EARTH MOVING? | | |
| ANY OPERATIONS INCLUDE BLASTING OR UTILIZE EXPLOSIVE MATERIAL? | | |
| DOES APPLICANT PERFORM OR ENGAGE IN ANY WORK OR OPERATION OTHER THAN THOSE LISTED IN THE CLASSIFICATION SCHEDULE OF THIS APPLICATION? IF YES, EXPLAIN: | | |
| REMARKS | | |

PRIOR CARRIER INFORMATION

| Category | Years: | Years: | Years: | Years: |
|---------------|--------|--------|--------|--------|
| Carrier | | | | |
| Policy Number | | | | |
| Limits | | | | |
| Total Premium | | | | |

LOSS HISTORY

Enter all claims or occurrence that may give rise to claims for the prior 3 years check here if none

| Date of occurrence | Type of occurrence | Amount Paid | Claims Open | Yes No | |
|--|--------------------|-------------|-------------|------------------------------|-----------------------------|
| | | | | Yes | No |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Any Policy or coverage declined, cancelled or non renewed during the prior 3 years | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, explain | | | | | |

Personal information about you may be collected from persons other than you, such information as well as other personal privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization, you have the right to review your personal information in our files and can request correction of any inaccuracies a more detailed description of your right and our practices regarding such information is available upon request. Contact your agent or broker for instruction on how to submit a request to us.

The agent has no authority to Bind coverage on behalf of Granada Insurance Company. The Agent has no right to MAKE, ALTER, MODIFY or DISCHARGE any CONTRACT or POLICY issued on the basis of this application.

The undersigned agrees that if the downpayment or full payment check is returned by the bank because of nonsufficient funds, coverage will be null and void from inception.

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.

This application is in compliance with Florida Statute 626.752 A copy has been furnished to the applicant or insured and coverage is () Bound Effective ____ (Time) ____ (Date) () Not Bound

I understand this application is not a binder unless indicated as such on this form by the Brokering Agent.

APPLICANT'S SIGNATURE _____ **DATE** _____
PRODUCER'S SIGNATURE _____ **DATE** _____