



OFFICE PACKAGE APPLICATION

Complete this application if you want coverage for your office building and contents. Please complete a separate application for each location.

GENERAL INFORMATION

Name of Insured: _____ **REQUESTED EFFECTIVE DATE:** _____

Legal Name of Entity or Practice: _____

Corporate Structure: Individual Corporation Other: _____ Number of years in current business: _____

Location Address: _____

Phone: () _____ Fax: () _____ E-mail: _____

BUILDING INFORMATION

1. Total Building Area: _____ Sq. Ft.

2. Area Occupied by Insured: _____ Sq. Ft.

3. Year Built: _____ If the building is more than 25 years old indicate if the following have been updated and the year:
 Roof _____ Plumbing _____
 Heating _____ Electrical _____

4. Construction Type:
 Joisted Masonry Masonry Non-Combustible
 Frame Non-Combustible
 Fire-Resistive Modified Fire-Resistive

5. Number of stories: _____

6. How long at this location? _____ Years _____ Months

7. Building Occupancy: Single Multiple

8. Building 75% Sprinklered? Yes No

9. Do you Own or Lease the building?

10. If you lease, are you required to insure the building?
 Yes No

PLEASE ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR CURRENT OR MOST RECENT COVERAGE.

DENTAL AND MEDICAL PROPERTY COVERAGE ONLY

1. Operatory and Office Equipment & Contents: _____ Number of Operatories _____ Number of Bays _____

PROPERTY COVERAGE- ALL APPLICANTS

1. REAL PROPERTY (BUILDING) Limit of Insurance Requested: _____

2. BUSINESS PERSONAL PROPERTY (CONTENTS) Limit of Insurance Requested: _____

3. Property Deductible: \$1000 \$2500 \$5000

4. Is there someone with an additional financial interest in the contents of your company or practice? (For example, an equipment lessee.) If more than one, please provide name(s) and address(es) on a sheet of your letterhead.
 Check here if this individual or entity are also to be listed as an additional insured on your General Liability.

6. Optional Coverage:
 General Liability: \$1M/\$2m \$2M/\$4m
 Flood Earthquake
 Workers' Compensation:
 # Full-Time Employees: ____ # Part-Time Employees: ____

Partners, Officers, Relatives to be Included or Excluded:

Name	Title or Relationship	Ownership %	Duties	Incl/Exc.

5. Standard Property Coverages:
 Employee Dishonesty Limit Requested: \$ _____
 Accounts Receivable Limit Requested: \$ _____
 Valuable Papers Limit Requested: \$ _____
 Computer Equipment & Software
 Limit Requested: \$ _____

Current Payroll (Do NOT include any Individuals Excluded Above): \$ _____
 Employee Benefits Welfare Pension Plan (ERISA BOND)
 Amount of Bond Requested: \$ _____ (Minimum 10% of Plan Value Required)
 Plan Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____



**IF YOU HAVE ANY QUESTIONS REGARDING THE COMPLETION OF THIS BUSINESS OFFICE PACKAGE APPLICATION, PLEASE CONTACT:
ROBERT ELLIS & ASSOCIATES
ATTN: PROPERTY & CASUALTY DEPT.
1-888-503-5547**

PROPERTY PROTECTION INFORMATION

1. Smoke detectors installed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Number of Fire Extinguisher(s): _____
2. Smoke detectors hard-wired?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Security Service? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Burglar Alarm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Surge Protector for Computers? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type? <input type="checkbox"/> Local <input type="checkbox"/> Silent <input type="checkbox"/> Central Station		8. Dead Bolt Locks on doors? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Fire Alarm?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Barred Windows? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type? <input type="checkbox"/> Local <input type="checkbox"/> Silent <input type="checkbox"/> Central Station		

OFFICE LOCATION

1. Describe commercial occupancies adjacent to the Insured's occupancy:

Left _____	Above _____
Right _____	Below _____

2. List other occupants in building: _____

PRIOR PROPERTY CARRIER INFORMATION – 3 YEARS MINIMUM

Policy Term (From/To)	Carrier	Policy #

PLEASE PROVIDE A COPY OF MOST RECENT DECLARATIONS PAGE.

PROPERTY LOSS INFORMATION

List all prior claims reported to carrier within 3 years.

1. No prior losses in 3 years

2. Complete claims history below:

LOSS DATE	DESCRIPTION OF LOSS	\$ AMOUNT PAID	\$ AMOUNT RESERVE	OPEN	CLOSED

3. To the best of your knowledge, are there any incurred by not reported losses? Yes No

X

APPLICANT'S SIGNATURE

DATE

FRAUD WARNING NOTICE:

Any person who knowingly and with intent to defraud any insurance company or other 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. Such person may be subject to a civil penalty as determined by the laws of the state in which the carrier is domiciled and the stated value of the claim for each such violation.

**PLEASE RETURN YOUR COMPLETED APPLICATION TO:
ROBERT ELLIS & ASSOCIATES, P.O. BOX 2140, MANDEVILLE, LA 70470**