

**PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOUR INSURANCE QUOTE.**

|   |                  |                     |                     |
|---|------------------|---------------------|---------------------|
| 1 | BUSINESS NAME    |                     | QUOTE<br>NEEDED BY: |
|   | OWNER'S NAME     | YEARS OF EXPERIENCE |                     |
|   | ADDRESS          |                     |                     |
|   | CITY, STATE, ZIP | COUNTY              |                     |

|   |              |            |                   |
|---|--------------|------------|-------------------|
| 2 | PHONE NUMBER | FAX NUMBER | CELL/PAGER NUMBER |
|---|--------------|------------|-------------------|

|   |   |                                      |   |
|---|---|--------------------------------------|---|
| 3 | CONTRACTORS LICENSE NUMBER<br>OR APPLICATION FEE NUMBER | CLASSIFICATION<br><b>A B C</b> _____ | <b>ENTITY</b><br>(CHECK ONE)    SOLE PROPRIETOR <input type="checkbox"/><br>PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> |
|---|---|--------------------------------------|---|

|                                       |   |   |  |
|---------------------------------------|---|---|--|
| 4                                     | DESCRIBE THE SCOPE OF YOUR WORK/OPERATIONS. |   | NUMBER OF OWNERS<br>ACTIVE IN THE FIELD: _____ |
|                                       | _____                                       |   |  |
|                                       | _____                                       |   |  |
|                                       | _____                                       |   |  |
| PERCENTAGE OF COMMERCIAL WORK _____%  |   | (New construction _____% Remodel _____% Service/Repairs _____%) |  |
| PERCENTAGE OF RESIDENTIAL WORK _____% |   | (New construction _____% Remodel _____% Service/Repairs _____%) |  |

|   |   |  |
|---|---|--|
| 5 | <b>YOUR FINANCIAL ESTIMATE FOR THE NEXT 12 MONTHS.</b>  |  |
|   | GROSS RECEIPTS \$ _____<br><small>(include labor, materials, subcontract cost, profit and overhead)</small> | SUBCONTRACTOR COSTS \$ _____                     |
|   | FIELD PAYROLL \$ _____  | (Excluding officers, owners, and clerical staff) |

|   |   |
|---|---|
| 6 | DO YOU PLAN TO WORK ON: <input type="checkbox"/> NEW TRACT HOMES <input type="checkbox"/> CONDOS <input type="checkbox"/> APARTMENTS <small>(Please check all that apply)</small> |
|   | NUMBER OF UNITS PER PROJECT _____    PERCENT OF GROSS RECEIPTS _____  |
|   | DO YOU DO ANY ROOFING OR ROOFING REPAIRS?    YES <input type="checkbox"/> NO <input type="checkbox"/>   |

|   |  |                         |                           |                           |
|---|--|-------------------------|---------------------------|---------------------------|
| 7 | <b>WHAT LIMITS OF GENERAL LIABILITY ARE YOU INTERESTED IN? (Circle choice/choices)</b>   |                         |                           |                           |
|   | \$300,000 / \$500,000  | \$500,000 / \$1,000,000 | \$1,000,000 / \$1,000,000 | \$1,000,000 / \$2,000,000 |
|   | <b>SPECIAL NEEDS (Mark all that apply)</b><br>Double aggregate limits.    Higher than \$1,000,000 occurrence limits.    Additional insured certificates with special wording.<br>Carrier with a rating of _____    Current Carrier: _____    Policy Expires: _____ |                         |                           |                           |

|   |  |                       |
|---|--|-----------------------|
| 8 | <b>FOR WORKER'S COMPENSATION.</b>                                      |                       |
|   | Payroll \$ _____ per hour / \$ _____ per year / Current Carrier: _____ | Policy Expires: _____ |

|                  |  |                      |                               |                |
|------------------|--|----------------------|-------------------------------|----------------|
| 9                | <b>FOR BUSINESS AUTO.</b> <small>(attach list for additional vehicles)</small> |                      |                               |                |
|                  | Type of vehicle _____  | Model _____          | Year _____                    | Cost New _____ |
| Deductible _____ |  | Comp/Collision _____ | Driver's license Number _____ |                |

Please fax or mail this completed form back to us so we can get started on your quote.  
**CALL TOLL FREE 1-888-900-9989 • Phone: (916) 361-9585 • Fax: (916) 361-9821**