



# FAX IT BACK ⇨ 888-754-8329

Please complete and fax back three pages for your free quote.

Call 800-228-7548 if you have any questions.

## Combination Application for Workers' Compensation, Business Package, and Commercial Auto

### General Information

Practice Owner: \_\_\_\_\_ Practice Name \_\_\_\_\_

Insurance Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Practice Address: \_\_\_\_\_ (city/state/zip) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ (city/state/zip) \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Legal Structure:  Sole Proprietor  Partnership  Corporation  Limited Liability Company  Other: \_\_\_\_\_

Practice Type:  Small Animal Exclusive  Predominantly Equine  Mixed *mostly small animal*  Mixed *mostly large animal*

### Workers' Compensation

*Workers' compensation is not available in monopolistic states: North Dakota, Ohio, Washington, and Wyoming. Please skip ahead to the Practice Owners Package Program section.*

List **all** owners and officers of the practice and indicate if included or excluded (attach an additional page if necessary):

\_\_\_\_\_  Include  Exclude ♦ Estimated Annual Payroll \_\_\_\_\_

\_\_\_\_\_  Include  Exclude ♦ Estimated Annual Payroll \_\_\_\_\_

\_\_\_\_\_  Include  Exclude ♦ Estimated Annual Payroll \_\_\_\_\_

\_\_\_\_\_  Include  Exclude ♦ Estimated Annual Payroll \_\_\_\_\_

\_\_\_\_\_  Include  Exclude ♦ Estimated Annual Payroll \_\_\_\_\_

\_\_\_\_\_  Include  Exclude ♦ Estimated Annual Payroll \_\_\_\_\_

\_\_\_\_\_  Include  Exclude ♦ Estimated Annual Payroll \_\_\_\_\_

Do you have other locations?  Yes  No ♦ Years in business: \_\_\_\_\_

Location Address: \_\_\_\_\_ (city/state/zip) \_\_\_\_\_

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Type of Employee	Class Code	Number of Employees Full/Part Time	Estimated Annual Payroll
Employed Veterinarians and Assistants (class code includes Receptionists)	8831		
Executive Officers, Partners, Proprietors, and Owners (only if included in coverage)	8831		
Clerical Duties Only (No Animal Contact)	8810		

## Workers' Compensation continued

Federal Tax ID# \_\_\_\_\_ What is your experience modification factor? \_\_\_\_\_  No experience modification factor

How many people regularly drive (farm calls, errands, transportation)? \_\_\_\_\_ Any under 21?  Yes  No If yes, please list:

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DL# \_\_\_\_\_ State: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DL# \_\_\_\_\_ State: \_\_\_\_\_ Date Issued: \_\_\_\_\_

## Insurance Information

Has any insurer canceled or declined to renew your workers' compensation insurance during the past three years?  Yes  No

If yes, explain \_\_\_\_\_

When does your current insurance expire? \_\_\_\_\_ Current Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_

Please list the previous three years insurance information:

Dates of Coverage: \_\_\_\_\_ Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_

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Dates of Coverage: \_\_\_\_\_ Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_

Please describe all claims in the past three years and the approximate cost of each claim (attach an additional page if necessary):

Date: \_\_\_\_\_ Description: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

## Practice Owners Package

Current Business Policy Expiration Date: \_\_\_\_\_ Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_

Please describe any claims in the last five years and the approximate cost of each claim (attach an additional page if necessary):

Date: \_\_\_\_\_ Description: \_\_\_\_\_ \$ \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ \$ \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ \$ \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ \$ \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ \$ \_\_\_\_\_

*Commercial General Liability* (excluding Professional Liability): \$2,000,000/occurrence ♦ *Umbrella Liability* (excluding Professional Liability): \$1,000,000

Building Limit: \_\_\_\_\_ Deductible: \_\_\_\_\_ Business Personal Property Owned: \_\_\_\_\_

Business Personal Property Off Premises Limit: \_\_\_\_\_ Business Personal Property of Others (leased): \_\_\_\_\_

Do you need earthquake coverage?  Yes  No ♦ Do you need flood coverage?  Yes  No ♦  Own  Lease

Construction:  Frame  Joisted Masonry  Masonry  Non-Combustible  Other: \_\_\_\_\_

Alarm System:  Local  Central Station ♦ Smoke Detectors:  Yes  No ♦ Fire Extinguishers:  Yes  No

Fire Department:  Paid  Volunteer/ \_\_\_\_\_ miles ♦ Sprinklers:  Yes  No ♦ Locale:  Urban  Suburban  Rural

Number of Stories: \_\_\_\_\_ Sq. Ft. Area: \_\_\_\_\_ Year Built: \_\_\_\_\_ Years in Business: \_\_\_\_\_ If Multiple Occupancy: \_\_\_\_\_% occupied

If over 30 years old, please attach date and extent of renovations for wiring, plumbing, heating and roofing.

# Mobile Veterinarians

Are you exclusively mobile?  Yes  No ♦ Percentage of practice that is mobile: \_\_\_\_\_%

Number of veterinarians: \_\_\_\_\_ Number of veterinarians owning permanently attached equipment: \_\_\_\_\_

Do you want business interruption coverage for loss of income by a covered auto loss?  Yes  No

# Commercial Auto Coverages

*If you do not need auto insurance, please skip to the next section.*

Current Auto Policy Expiration Date: \_\_\_\_\_ Insurer: \_\_\_\_\_ Premium: \_\_\_\_\_

Liability per accident:  \$1,000,000  \$500,000  \$300,000

Comprehensive Deductible:  \$500  \$1,000 ♦ Collision Deductible:  \$500  \$1,000

Towing and Labor (if available):  Yes  No ♦ Rental Reimbursement:  Yes  No

Vehicle Descriptions (attach an additional page if necessary):

Year: \_\_\_\_\_ Make/Model/Body: \_\_\_\_\_ VIN: \_\_\_\_\_ Cost New: \_\_\_\_\_

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Year: \_\_\_\_\_ Make/Model/Body: \_\_\_\_\_ VIN: \_\_\_\_\_ Cost New: \_\_\_\_\_

Do you own a vet box?  Yes  No ♦ Is it permanently attached?  Yes  No ♦ What is the cost new? \_\_\_\_\_

Driver Information (attach an additional page if necessary):

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DL# \_\_\_\_\_ State: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DL# \_\_\_\_\_ State: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ DL# \_\_\_\_\_ State: \_\_\_\_\_ Date Issued: \_\_\_\_\_

Are all vehicles solely owned by and registered to the applicant?  Yes  No ♦ Are any vehicles leased to others?  Yes  No

Garage address:  Same as practice  Other: \_\_\_\_\_ (city/state/zip) \_\_\_\_\_

Have there been any DUIs/DWIs for any drivers?  Yes  No ♦ If yes, what year(s)? \_\_\_\_\_

Are any vehicles customized, altered or have special equipment?  Yes  No ♦ What is the radius driven? \_\_\_\_\_

Please describe all auto claim and ticket information in the past three years (attach an additional page if necessary):

Date: \_\_\_\_\_ Description: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

Date: \_\_\_\_\_ Description: \_\_\_\_\_ Amount Paid: \_\_\_\_\_

# Signature

Bind coverage effective: \_\_\_\_\_ (Coverage cannot be backdated.)

X \_\_\_\_\_ Date: \_\_\_\_\_

*Completion of this application does not commit either party. In the event of conflict, the conditions and terms of the policy prevail. This contains a brief description of coverage and does not include all the benefits and limitations found in the policy. Coverage is subject to the policy terms and exclusions. The AVMA PLIT is not an insurance company.*

Do not include quote for workers' compensation extended broad form endorsement. This endorsement provides coverage for volunteers and raises the employers liability limit from \$100,000 to \$500,000. The cost is 3% of the premium.

*Trust Broker and Consultant since 1962: Hub International Midwest Limited ♦ Hub International Midwest Insurance Agency (CA)*

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