



Selective Associates, Inc.

Small Business Quick Application

Applicant Name: _____
 Mailing Address: _____
 Phone: _____ Fax: _____ Email: _____
 Owner Name: _____
 Business Description: _____
 # of Employees: _____ Full Time: _____ Part Time: _____ Male: _____ Female: _____
 Location #1 Address: _____
 Location #2 Address: _____

Coverage Information	Location #1	Location #2
Building Coverage	\$ _____	\$ _____
Business Personal Property	\$ _____	\$ _____
Deductible	\$500.00 \$1,000.00 \$2,500.00	\$500.00 \$1,000.00 \$2,500.00
Business Income / Extra Expense	Included Excluded \$ _____	Included Excluded \$ _____
Total Gross Sales (Annual)	\$ _____	\$ _____
Total Annual Payroll	\$ _____	\$ _____
Glass Coverage (Tenants)	Yes No SqFt _____	Yes No SqFt _____
Other Occupancies	_____	_____
Total Square Ft Occupied	_____	_____
Construction Of Building	Frame - Brick - NC - Fire Res	Frame - Brick - NC - Fire Res
Sprinklered	Yes - No	Yes - No
Type Of Coverage Form	Special - Broad - Basic	Special - Broad - Basic
Year Building Was Built	_____	_____
Year Building Updated	Electrical _____ Plumbing _____ Heating _____ Roof _____	Electrical _____ Plumbing _____ Heating _____ Roof _____
Liability Limit Requested	\$300,000 \$500,000 \$1,000,000	\$300,000 \$500,000 \$1,000,000
Employee Benefits Liability	Included Excluded	Included Excluded
Equipment Breakdown	Included Excluded	Included Excluded
Business Automobile:		
Y Combine Single Limit	\$300,000 \$500,000 \$1,000,000	\$300,000 \$500,000 \$1,000,000
Y Personal Injury Protection W/Addl	\$50,000 \$100,000 \$150,000	\$50,000 \$100,000 \$150,000
Y Medical Payments	\$5,000 \$10,000	\$5,000 \$10,000
Y Comp / Collision Deductible	\$500 \$1,000 \$1,500	\$500 \$1,000 \$1,500



Selective Associates, Inc.

Small Business Quick Application

Ȳ Vehicle #1 Make_____	Vin#_____ Cost New\$_____	GVW _____ Comp Collision
Ȳ Vehicle #2 Make_____	Vin#_____ Cost New\$_____	GVW _____ Comp Collision
Ȳ Vehicle #3 Make_____	Vin#_____ Cost New\$_____	GVW _____ Comp Collision
Ȳ Vehicle #4 Make_____	Vin#_____ Cost New\$_____	GVW _____ Comp Collision
Workers Compensation Wanted	Yes - No	Yes - No
Executive Officers (WC)	Included Excluded	Included Excluded
Payroll For Executive Officers	\$_____	\$_____
New York State Disability	Yes - No	Yes - No
Health Insurance	#Employee____ #Family_____	#Employee____ #Family_____
Life Insurance for Owners	Amount \$ _____ Type: Term Permanent Age_____Smoke Y N	Amount \$ _____ Type: Term Permanent Age_____Smoke Y N
Umbrella Liability Wanted	Yes No Limit: \$_____	Yes No Limit: \$_____

Prior Carrier Information:

- Who is the prior carrier?
- Were there any losses?
- How long insured?
- If no prior carrier: How long has the insured worked in this field?