



Request For Indication

For office use only

Association Member Benefits Advisors, LLC.

- A. Please type or print clearly in ink.
 - B. All applicants should complete Section 1-Business Information. Complete Section 2-Business Owners Package and/or Section 3-Worker's Compensation on if coverage is desired.
 - C. Provide a copy of your expiring Declarations page for each selected coverage as well as any optional coverage and/or schedule pages.
- If you need additional space, please continue on a separate sheet of your business letterhead.

Supplemental information may be required.

Contact information:

Business Name: _____
 Mailing Address: _____

 Location Address: _____
 (include county) _____
 Contact Name: _____
 Phone Number: _____
 Fax Number: _____
 E-mail Address: _____
 Website Address: _____

Section 1-Business Information

Detailed business description that includes all operations: _____
 Professional Organization Memberships: _____
 Business Type (please select one): Sole Proprietorship _____ Partnership _____ Corporation _____ Other (please explain _____)
 Estimated Annual Receipts: \$ _____
 Number of years in business: _____
 Number of years of experience in field: _____
 Do you own or operate any other business other than the business listed above? Yes No If yes, describe operations: _____

Section 2-Business Owners Package

Requested Effective Date:

Property Information:

Building Replacement Costs (if you own it) \$ _____

If building coverage is being provided, list all occupants and provide the square footage of each occupant's space. Also, please indicate the square footage of any vacant area.

Contents Replacement Costs Value \$ _____
 -Includes equip., supplies, furniture, improvements and betterments (in lease)

Location Information:

- Check appropriate box for Building Construction*
- Frame Non-Combustible
 - Joisted Masonry Masonry Non-Combustible
 - Fire Resistive

*see construction definitions on bottom of page 2

Building Age _____ 100% Sprinklered Yes No

No. of Stories _____ Occupied Square Footage _____

Is location building over 30 years old? Yes No
If yes to above, please provide the year of update for each of the following:

Plumbing _____ Electrical _____ Heating _____ Roof _____

Any exposing property within 60 feet of property? Yes No *If yes, please describe.*

Liability Information:

Check appropriate box for General Liability limits needed

- \$300,000/\$600,000 \$1,000,000/\$2,000,000
- \$500,000/\$1,000,000 \$2,000,000/\$4,000,000

Insurance History:

Please provide insurance history for the past 3 years. If there was no coverage in place for a given year, please indicate "None".

Insurance Company	Policy Number	Expiration Date	Annual Premium	# of Claims

Has any like coverage been declined, cancelled, or non-renewed within the past 3 years? Yes No If yes, please explain.

Section 3-Worker's Compensation**Requested Effective Date:** _____
 Federal Employers Identification Number: _____
 Unemployment Number (if applicable): _____
 NCCI or Experience Mod Factor (if applicable): _____

 Number of Full Time Employees: _____
 Number of Part-time Employees: _____
 Employees Estimated Annual Payroll: \$ _____
 Officers Estimated Payroll: \$ _____

The following information is required of all owners, officers, and/or partners associated with the business. State laws differ in whether owners, officers, and/or partners have to be included or excluded in coverage. Please consult your states insurance department for specific regulations before opting to be excluded from coverage.

<i>Officers Name</i>	<i>Include or Exclude</i>	<i>Title/Relationship</i>	<i>Ownership %</i>	<i>Annual Payroll</i>

Insurance/Claims History:

Please provide insurance history for the past 5 years. If there was no coverage in place for a given year, please indicate "None".

<i>Insurance Company</i>	<i>Policy Number</i>	<i>Expiration Date</i>	<i>Annual Premium</i>	<i># of Claims</i>

Has any coverage been declined, cancelled, or non-renewed within the past 3 years? Yes No If yes, please explain.

Section 4-Additional Coverage

Please indicate whether or not you would like to receive additional information and/or a premium indication on the following lines of coverage:

Hired and Non-Owned Auto	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Business Auto	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Commercial Umbrella	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Professional Liability	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PLEASE READ, SIGN, AND DATE:

The applicant declares the information contained in the application is true and that no material facts have been suppressed or misstated. The applicant understands that incorrect or incomplete information could void their protection.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

This application is subject to the underwriter's approval. Your completion of this application does not obligate the insurance company to issue your insurance coverage.

Signature of Principal Owner, Officer, or Partner

Date

Return your signed application to:

AMBA
PO Box 14521
Des Moines, IA 50306
Fax: 515-993-9681

Plan offered through Association Member Benefits Advisors, LLC (AMBA). After approval of your application, your Certificate and premium notice will be sent directly to you. The completion of this application does not bind coverage. The application is subject to the Company's Underwriting Rules.

***Construction Definitions**

Frame: Wood or mostly wood construction.

Joisted Masonry: Brick, block, concrete load bearing walls. Roof and floor supports are wood.

Non-Combustible: Metal structural wall and roof supports. NO wood roof decking or wood siding.

Masonry Non-Combustible: Masonry load bearing walls and unprotected steel roof supports.

Fire Resistive: Masonry or protected steel load bearing walls and roof supports. (Steel is protected by encasing it in concrete or spraying on fire resistive insulation.)

CALIFORNIA INSUREDS ONLY-- INSURANCE SUPPLEMENT

CALIFORNIA DEPARTMENT OF INSURANCE RACE, NATIONAL ORIGIN, & GENDER FORM

(Applicable only to individuals, DBAs, Sole Proprietorships and single person corporations)

In order to aid the Insurance Commissioner of the State of California to monitor the insurer's compliance with the law, all applicants are requested to voluntarily provide the following information. Please note that this section will be separated from the application prior to processing. No information shall be used for underwriting or rating any applicant or policyholder.

Applicant's Name and Address	Application Type- Please check all that apply
<hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Commercial Package (including fire, general liability) <input type="checkbox"/> Commercial Auto Liability <input type="checkbox"/> Commercial Auto Physical Damage <input type="checkbox"/> Other Liability

Under this Regulation, Race or National Origin means one of the following categories. Please check the box for the combination that describes you:

CATEGORIES	APPLICANT		CO-APPLICANT	
	Male	Female	Male	Female
African-American	<hr/>	<hr/>	<hr/>	<hr/>
American Indian or Alaskan Native	<hr/>	<hr/>	<hr/>	<hr/>
Asian (Oriental)	<hr/>	<hr/>	<hr/>	<hr/>
Asian (Other)	<hr/>	<hr/>	<hr/>	<hr/>
Latino (Not Brazilian or Portuguese)	<hr/>	<hr/>	<hr/>	<hr/>
Middle Eastern	<hr/>	<hr/>	<hr/>	<hr/>
Pacific Islander	<hr/>	<hr/>	<hr/>	<hr/>
White	<hr/>	<hr/>	<hr/>	<hr/>
Other (specify) _____	<hr/>	<hr/>	<hr/>	<hr/>
Information not provided by Applicant(s)	<hr/>	<hr/>	<hr/>	<hr/>

Insurance Company: _____