

Inland Marine Basic Application

Complete this page or ACORD 125.
Attach application for appropriate line(s) of coverage.

| PRODUCER INFORMATION | | | | | | | | | | | | | |
|---|------|----------------------------|----------------------------|--------------------------------------|----------------------------|--|---------------------------|------------------------------|----------------------------|-----------------------------|----------------------------|----------------------------------|--|
| Agency Name: _____ | | | | | | | | | | | | | |
| Address: _____ | | | | | | | | | | | | | |
| City: _____ | | | | | | | | | | | | | |
| State: _____ | | | | | | | | | | Zip: _____ | | | |
| Producer Code: _____ (six digits) | | | | | | Submitted by: _____ Phone Number: _____ | | | | | | | |
| APPLICANT INFORMATION | | | | | | | | | | | | | |
| First Named Insured: _____ | | | | | | | | | | | | | |
| Address: _____ | | | | | | | | | | | | | |
| City: _____ | | | | | | | | | | ST: _____ | | Zip: _____ | |
| Years _____ | | | | ... at this location | | | | ... in this business | | | | | |
| Attachments? | | Additional named insureds? | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | Loss payees & addressees? | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | | |
| Action: | | Quote | | Issue | | Bound (date, time effective): _____ | | | | | | | |
| Billing: | | Agency | | Direct | | Payplan: _____ | | | | | | | |
| Do you presently write this account? | | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | How long have you known applicant? _____ | | | | | | | |
| Present Carrier: | | | | Premium/Rate: _____ | | | | | | | | | |
| Desired Effective Date: | | | | Desired Expiration Date: _____ | | | | | | | | | |
| Any other insurance with this Company or being submitted? | | | | | | | | <input type="checkbox"/> Yes | | <input type="checkbox"/> No | | If yes, identify under "Remarks" | |
| Describe Operations: <div style="border: 1px solid black; height: 40px; width: 100%;"></div> | | | | | | | | | | | | | |
| Gross Annual Sales: \$ _____ | | | | | | | | | | | | | |
| Any policy/coverage declined, cancelled or non-renewed in past 3 years? (Not applicable in MO) | | | | | | | | | | <input type="checkbox"/> Y* | | <input type="checkbox"/> N | |
| If so, for what reason? _____ | | | | | | | | | | | | | |
| Has applicant ever filed bankruptcy or reorganization? | | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | Date: _____ | | | Court: _____ | | | | |
| For inspection, contact (name, phone number): _____ | | | | | | | | | | | | | |
| LOSS HISTORY (past 5 years) | | | | | | | | | | | | | |
| Ln# | Date | Amount Pd. | Open Ctm? | | Deductible | Cause of Loss | Prevention Implemented | | | | | | |
| | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | |
| | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | |
| | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | |
| | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | |
| No losses in the past 5 years. | | | | More loss history on attached pages? | | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | | | | |
| REMARKS | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

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 act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

Applicant Signature, Date: _____

Producer Signature, Date: _____

F. 170 (6/97)