

Steadfast Insurance Company

General Application for Insurance

(Supplemental Application needed)

Dover, Delaware

Administrative Offices: 1400 American Lane, Schaumburg, Illinois 60196-1056



Please type or print

Proposed effective date:	
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A. Applicant

Full name:					
Principal Address:					
City:		State:			
Website address:					
Insurance contact:		Insurance contact phone number:			
<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		
Type of operation:	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Manufacturer <input type="checkbox"/> Wholesaler <input type="checkbox"/> Retailer <input type="checkbox"/> Importer <input type="checkbox"/> Exporter </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> Contractor <input type="checkbox"/> Premises: Habitational/Commercial <input type="checkbox"/> Service <input type="checkbox"/> Other _____ </td> </tr> </table>			<input type="checkbox"/> Manufacturer <input type="checkbox"/> Wholesaler <input type="checkbox"/> Retailer <input type="checkbox"/> Importer <input type="checkbox"/> Exporter	<input type="checkbox"/> Contractor <input type="checkbox"/> Premises: Habitational/Commercial <input type="checkbox"/> Service <input type="checkbox"/> Other _____
<input type="checkbox"/> Manufacturer <input type="checkbox"/> Wholesaler <input type="checkbox"/> Retailer <input type="checkbox"/> Importer <input type="checkbox"/> Exporter	<input type="checkbox"/> Contractor <input type="checkbox"/> Premises: Habitational/Commercial <input type="checkbox"/> Service <input type="checkbox"/> Other _____				

Named Insureds: include JV's, Partnerships, Trusts, Subsidiaries, etc

Insured	Relationship	Description of Operations

**If you want to learn more about the compensation Zurich pays agents and brokers visit:
<http://www.zurichnaproducercompensation.com> or call the following toll-free number: (866) 903-1192.
 This Notice is provided on behalf of Zurich American Insurance Company and its underwriting subsidiaries.**

B. Operations

# of years in business under present name:	
Prior experience in this business under another name:	

Describe the nature of operations. Indicate which products you install, service or repair:

Attach brochures, catalogs, labels, instruction manuals, annual reports, D&B's, Product Safety Surveys, etc.)

Exposure History:

Exposure Base	Estimated	Expiring	1 st Prior	2 nd Prior	3 rd Prior	4 th Prior
Sales/Receipts						
Payroll						
Area						
Contract Costs						
Number of locations/projects						
Units						

Describe any discontinued operations, divestitures or acquisitions and those planned for introduction in the next 12 months.

C. **Claim History** – Please provide five (5) years of currently valued loss runs. Loss total should be from first dollar, including defense costs:

Policy Period	Name of Carrier	Date of loss data	# of claims open	# of claims closed	Total amount paid	Total amount reserved	Total incurred

Description of Large Individual Losses, valued at \$10,000 or greater.

Date of Loss	Open/Closed	Amount	Claimant	Description of Loss

D. Prior Carrier Information / Current Program

	Current/Expiring	1 st Prior	2 nd Prior	3 rd Prior	4 th Prior
Carrier					
Policy Number					
Policy Type	CM/Occur	CM/Occur	CM/Occur	CM/Occur	CM/Occur
Retro Date					
Eff-Exp Date					
LIMITS					
Each Occurrence					
Personal & Adv Injury					
General Aggregate/PCO Aggregate					
Fire Damage					
Medical Expense					
Retention					
- Type	Ded/SIR	Ded/SIR	Ded/SIR	Ded/SIR	Ded/SIR
Amount	\$	\$	\$	\$	\$
Total Premium					

Has any insurer ever canceled, restricted or refused to renew your products liability insurance? If "yes", please attach details.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Details if needed:
Insurance Requested:	Limits desired: \$		SIR / deductible desired: \$

Warranty

I/We warrant that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy.

Signature of applicant: _____ Date: _____

Title: _____ (owner, partner, officer)

* Signing this form does not bind the applicant or the company to complete the insurance. Application must be signed by the applicant and dated to be considered for quotation.

SUBMITTED BY:

Producer:					
Address:					
City:		State:		Zip Code:	