



**Mercer Consumer**

a service of *Mercer Health & Benefits Administration LLC*

For office use only

- 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: \_\_\_\_\_

<p><b>Section 2-Business Owners Package</b></p> <p><u>Property Information:</u>          Building Replacement Costs (if you own it) \$ _____</p> <p>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.</p> <p>Contents Replacement Costs Value \$ _____          -Includes equip., supplies, furniture, improvements and betterments (in lease)</p> <p><u>Location Information:</u>          Check appropriate box for Building Construction*  <input type="checkbox"/> Frame <input type="checkbox"/> Non-Combustible  <input type="checkbox"/> Joisted Masonry <input type="checkbox"/> Masonry Non-Combustible  <input type="checkbox"/> Fire Resistive</p> <p><small>*see construction definitions on bottom of page 2</small></p>	<p><b>Requested Effective Date:</b> _____</p> <p>Building Age _____ Sprinklers <input type="checkbox"/> Yes <input type="checkbox"/> No          If sprinkled, are they wet or dry?</p> <p>No. of Stories _____ Occupied Square _____          Air Conditioner <input type="checkbox"/> Yes <input type="checkbox"/> No Footage _____</p> <p>Is location building over 30 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes to above, please provide the year of update for each of the following:          Plumbing _____ Electrical _____ Heating _____ Roof _____</p> <p>Any exposing property within 60 feet of property? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe.</p> <p><u>Liability Information:</u>          Check appropriate box for General Liability limits needed  <input type="checkbox"/> \$300,000/\$600,000 <input type="checkbox"/> \$1,000,000/\$2,000,000  <input type="checkbox"/> \$500,000/\$1,000,000 <input type="checkbox"/> \$2,000,000/\$4,000,000</p>
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**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 3-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 Yes No Business Auto Yes No  
 Commercial Umbrella Yes No Professional Liability Yes 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:

Mercer Consumer  
 PO Box 14521  
 Des Moines, IA 50306  
 Fax: 515-365-3005

Administered by Mercer Consumer, a service of Mercer Health & Benefits Administration LLC. 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.)