

Janitorial Supplemental Application

Applicant's Name _____

Mailing Address _____

Web Address _____

Agent Name _____

Address _____

Proposed Effective Date:

From _____ To _____

(12:01 am Standard Time at the address of the Applicant)

Applicant is: Individual Corporation Partnership Joint Venture LLC Other _____

Years doing business under current name _____ years

Years of Experience _____ years

Have you worked under any other name?

Yes No

If yes, please explain: _____

***NOTE: Pollution clean up; Hazardous material clean up; Restaurant vent or hood cleaning; Fire suppression system cleaning are Prohibited Operations.**

Limits of Liability Requested	
Each Occurrence	\$
Personal & Advertising Injury	\$
Products & Completed Operations Aggregate	\$
General Aggregate	\$
Damages to Premise Rented to you	\$
Medical Expense (any one person)	\$
Other Coverages, Restrictions, or Endorsements requested:	
Deductible \$	BI/PD per Claim - LAE

Description of
Operations _____

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Personnel	Number	Annual Payroll/Cost
Owner(s)	#	\$
Employees (excl. clerical):	FT #	\$
	PT #	\$
Leased	#	\$
Independent Contractors	#	\$
Total Annual Payroll		\$

Type of Duties Performed

Operations	Payroll/Sales	Operations	Payroll/Sales
<input type="checkbox"/> Aircraft	\$	<input type="checkbox"/> Offices	\$
<input type="checkbox"/> Apartments	\$	<input type="checkbox"/> Off-Shore Oil Rigs	\$
<input type="checkbox"/> Construction Make-Ready	\$	<input type="checkbox"/> Private Residences	\$
<input type="checkbox"/> Convenience & Grocery Stores	\$	<input type="checkbox"/> Retail Stores	\$
<input type="checkbox"/> Conventions Halls	\$	<input type="checkbox"/> Schools/Colleges/Universities	\$
<input type="checkbox"/> Crime Scene Clean-Up	\$	<input type="checkbox"/> Shopping Centers & Malls	\$
<input type="checkbox"/> Department Stores	\$	<input type="checkbox"/> Sports Complexes	\$
<input type="checkbox"/> Hospitals/Convalescent Homes	\$	<input type="checkbox"/> Transportation Terminals	\$
<input type="checkbox"/> Hotels	\$	<input type="checkbox"/> Theaters	\$
<input type="checkbox"/> Industrial	\$	<input type="checkbox"/> Other:	\$
Total Annual Sales:			\$

Percentage of Operation

Residential _____ %	Commercial _____ %	Industrial _____ %
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Are Floor Waxing/Stripping services provided? Yes No

If yes, where are services provided, what time of day and at what percentage? _____

Total Payroll \$ _____

Are Window Cleaning services provided? Yes No

If yes, please provide maximum number of stories: _____ stories

Scaffolding & Rigging: Rented Owned

Are Certificates of Insurance provided for Independent Contractors? Yes No

Please provide a brief description of handling any hazardous waste & recyclables and storage of combustible materials:

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In the past 3 years has any company ever cancelled, non-renewed, declined or refused to issue similar insurance to you? Yes No

If yes, please describe. _____

Do you have any known events occurred prior to the proposed effective date of this policy that may result in a claim? Yes No

If yes, please describe. _____

Loss History

Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claims Status (Open or Closed)

Prior Carrier Information

Year	Carrier	Premium

This questionnaire does not bind the Applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be part of the basis of the contract should a policy be issued. By signing you are hereby certifying that all information is accurate to the best of your knowledge.

Applicants Signature _____ Date _____

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Agents Signature

_____ Date _____