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Marshall & Sterling Insurance
 300 Route 23 B
 Leeds, NY 12451

 800-724-0695
 518-943-7440, fax
 www.marshallsterling.com/leeds

Proper & Casualty Insurance Program

GENERAL INFORMATION:

Named Insured:			
Mailing Address:			
			Zip:
Effective Date:		# of Years in Operation:	
Executive Director:			
Contact Name:			
Telephone #:		Fax#:	
Email Address:			
NYS Agency applicant is licensed or certified by:			
Primary Funding Sources:			
Annual Budget: \$		Payroll: \$	
Is audit /review conducted by a CPA? <input type="checkbox"/>yes <input type="checkbox"/>no			
Briefly describe services provided (please attach newsletters and/or brochures:			
Description	# Full Time	# Part Time	# Independent Contractors
Staffing			
Volunteers			

PACKAGE POLICY

EFFECTIVE DATE: _____

Policy Level Coverages

General Liability Limits \$ _____ Per Occurrence \$ _____ Aggregate	Property Deductible (select one) <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$ _____ (other)
<input type="checkbox"/> Professional Liability : Supplemental application must be completed to quote this coverage	Hired & Non-Owned Auto Liability (select if you have no owned autos) <input type="checkbox"/>

Location #1

Street Address:	
City:	State:
Zip:	
Building Value: \$ _____	Business Personal Property: \$ _____
Age of bldg.:	If age>50yrs, date of renovation:
Total Sq. Ft. of Building:	Sq. Ft. occupied:
Please check appropriate protection, if applicable:	
♦ Burglar Alarm: <input type="checkbox"/> Local <input type="checkbox"/> Central Station	
♦ Fire Alarm: <input type="checkbox"/> Local <input type="checkbox"/> Central Station	
♦ Watchman Service <input type="checkbox"/>	♦ 24 Hour Staffing <input type="checkbox"/>
♦ Fully Sprinklered <input type="checkbox"/>	♦ Partially Sprinklered <input type="checkbox"/>
Sole Occupant: <input type="checkbox"/> yes <input type="checkbox"/> no	
List other occupants:	
Construction: <input type="checkbox"/> Frame <input type="checkbox"/> Joisted Masonry <input type="checkbox"/> Metal NC <input type="checkbox"/> Masonry NC/Fire Resistive	
Additional Insured's Name & Address: (please describe relationships)	
<input type="checkbox"/> Energy Equipment/System Breakdown Coverage (Boiler & Machinery) <input type="checkbox"/> Earthquake Option (additional information may be requested) <input type="checkbox"/> Flood Option (additional information may be requested)	

Location #2

Street Address:		
City:	State:	Zip:
Building Value: \$ _____	Business Personal Property: \$ _____	
Age of bldg.:	If age>50yrs, date of renovation:	
Total Sq. Ft. of Building:	Sq. Ft. occupied:	
Please check appropriate protection, if applicable:		
◆ Burglar Alarm: <input type="checkbox"/> Local <input type="checkbox"/> Central Station ◆ Fire Alarm: <input type="checkbox"/> Local <input type="checkbox"/> Central Station		
◆ Watchman Service <input type="checkbox"/> ◆ 24 Hour Staffing <input type="checkbox"/> ◆ Fully Sprinklered <input type="checkbox"/> ◆ Partially Sprinklered <input type="checkbox"/>		
Sole Occupant: <input type="checkbox"/>yes <input type="checkbox"/>no List other occupants:		
Construction: <input type="checkbox"/>Frame <input type="checkbox"/>Joisted Masonry <input type="checkbox"/>Metal NC <input type="checkbox"/>Masonry NC/Fire Resistive		
Additional Insured's Name & Address: (please describe relationships)		
Mortgagees and/or Loss Payees' Name & Address:		
<input type="checkbox"/> Energy Equipment/System Breakdown Coverage (Boiler & Machinery) <input type="checkbox"/> Earthquake Option (additional information may be requested) <input type="checkbox"/> Flood Option (additional information may be requested)		

Location #3

Street Address:		
City:	State:	Zip:
Building Value: \$ _____	Business Personal Property: \$ _____	
Age of bldg.:	If age>50yrs, date of renovation:	
Total Sq. Ft. of Building:	Sq. Ft. occupied:	
Please check appropriate protection, if applicable:		
◆ Burglar Alarm: <input type="checkbox"/> Local <input type="checkbox"/> Central Station ◆ Fire Alarm: <input type="checkbox"/> Local <input type="checkbox"/> Central Station		
◆ Watchman Service <input type="checkbox"/> ◆ 24 Hour Staffing <input type="checkbox"/> ◆ Fully Sprinklered <input type="checkbox"/> ◆ Partially Sprinklered <input type="checkbox"/>		
Sole Occupant: <input type="checkbox"/>yes <input type="checkbox"/>no List other occupants:		
Construction: <input type="checkbox"/>Frame <input type="checkbox"/>Joisted Masonry <input type="checkbox"/>Metal NC <input type="checkbox"/>Masonry NC/Fire Resistive		
Additional Insured's Name & Address: (please describe relationships)		
<input type="checkbox"/> Energy Equipment/System Breakdown Coverage (Boiler & Machinery) <input type="checkbox"/> Earthquake Option (additional information may be requested) <input type="checkbox"/> Flood Option (additional information may be requested)		

AUTOMOBILE

EFFECTIVE DATE: _____

Policy Coverages	
Coverage	Limit
Liability	\$
PIP (no fault)	\$
Med Pay	\$
Uninsured Motorist	\$
Underinsured Motorist	\$
Hired & Non-Owned	\$

Vehicle #1

Year	Make	Model	Comp Ded	Collision Ded	Cost New	Vin #

Garaging Location:		
City:	State:	Zip:
Vehicle Usage:		
Radius of Operation:		
Additional Coverages (specify):		
Vehicle Weight: <input type="checkbox"/> 0-10,000lbs <input type="checkbox"/> 10,001-20,000lbs <input type="checkbox"/> 20,001+lbs		
<input type="checkbox"/> Commercial <input type="checkbox"/> Service <input type="checkbox"/> Private Passenger		
<input type="checkbox"/> Rental Reimbursement \$ per day/ days		
<input type="checkbox"/> Towing & Labor		
Loss Payee:		

Vehicle #2

Year	Make	Model	Comp Ded	Collision Ded	Cost New	Vin #

Garaging Location:		
City:	State:	Zip:
Vehicle Usage:		
Radius of Operation:		
Additional Coverages (specify):		
Vehicle Weight: <input type="checkbox"/> 0-10,000lbs <input type="checkbox"/> 10,001-20,000lbs <input type="checkbox"/> 20,001+lbs		
<input type="checkbox"/> Commercial <input type="checkbox"/> Service <input type="checkbox"/> Private Passenger		
<input type="checkbox"/> Rental Reimbursement \$ per day/ days		
<input type="checkbox"/> Towing & Labor		
Loss Payee:		

Vehicle #3

Year	Make	Model	Comp Ded	Collision Ded	Cost New	Vin #

Garaging Location:
City: _____ State: _____ Zip: _____
Vehicle Usage:
Radius of Operation:
Additional Coverages (specify):
Vehicle Weight: <input type="checkbox"/> 0-10,000lbs <input type="checkbox"/> 10,001-20,000lbs <input type="checkbox"/> 20,001+lbs
<input type="checkbox"/> Commercial <input type="checkbox"/> Service <input type="checkbox"/> Private Passenger
<input type="checkbox"/> Rental Reimbursement \$ _____ per day/ _____ days
<input type="checkbox"/> Towing & Labor
Loss Payee:

DRIVER INFORMATION

Please list all drivers. This included employees using their own vehicles for business purposes.

Driver Name	Date of Birth	License Number	Issuance State

Drivers must have the type of license required by their states for the vehicles operated. Please answer the following questions regarding motor vehicle violations occurring in the past three years (unless otherwise noted).

Has any drivers' license been suspended or revoked?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has any driver been arrested for:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<ul style="list-style-type: none"> • Driving while intoxicated, or under the influence of alcohol or drugs? • Reckless driving or similar violations (e.g., racing)? • For speeds more than 25 mph over the posted limit? • For criminal type convictions (e.g. negligent homicide, manslaughter, hit & run)? • Driving without a license? • Failure to report an accident or making a false report to authorities? 		
Has any driver had three or more at fault accidents and/or moving violations in the past three years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has any driver had two or more at fault accidents and/or moving violations in the past three years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

If "YES" is answered to any of the questions above, please document the name of the driver involved, date of birth, driver's license number and state.

OPERATIONS

Does your organization do any of the following? (If so, please explain below)

1. Provide any regulatory, inspection, certification accreditation, setting or reviewing standards of similar services? Yes No
2. Engage in lobbying or political action? Yes No
3. Provide any publications, internet or broadcasting services? Yes No
4. Do you own or manage any property other than offices & contents? Yes No
5. Provide any type of medical or health related services? Yes No
6. Provide any counseling, support, intake, referral services, crisis intervention, hot lines or other direct client services? Yes No
7. Conduct any special events or fund raisers off premises? Yes No

Expanations/comments: _____

THE FOLLOWING MUST BE COMPLETED TO PROPERLY QUOTE YOUR COVERAGE.

5 Year Loss Information: Property, Liability, Crime, Automobile, Workers Comp, & Umbrella
 (Company loss runs may be attached in lieu of completing loss information). check here if none

Loss Date	Loss Description	Paid/Reserved

Please provide carrier and premium information for your current coverage:

Property/Liability	
Automobile	
Workers Comp	
Umbrella	

I understand that this application provides coverage highlights only and that I must read my policy(ies) to determine full coverages and exclusions provided. I hereby declare that the statements made in this application are complete and true. The signing of this application does not bind the application for coverage.

Applicant	Applicant/Title	Date

