



**Commercial Insurance (Package and Liability Only) Questionnaire**

1. Legal name of Business: \_\_\_\_\_ DBA \_\_\_\_\_
2. Type of Business: \_\_\_\_\_ Other: \_\_\_\_\_
3. Business Nature (be specific and detailed):  
\_\_\_\_\_
4. FEIN#: \_\_\_\_\_ Year Business Started: \_\_\_\_\_
5. Tel#: \_\_\_\_\_ Fax#: \_\_\_\_\_
6. Website: \_\_\_\_\_ Email Address: \_\_\_\_\_
7. Physical Address: \_\_\_\_\_
8. Mailing Address (if different from physical address): \_\_\_\_\_
9. # of Locations: \_\_\_\_ (Note: If more than 1 loc, please complete #8-19 for each loc & include address)
10. Total Building Area: \_\_\_\_\_ sq. Ft. The Area you occupy: \_\_\_\_\_ sq. ft.
11. Year Building Built: \_\_\_\_\_
12. If building older than 1995, provide year last updated: Electrical \_\_\_\_\_  
Heating \_\_\_\_\_ Plumbing \_\_\_\_\_ Roof \_\_\_\_\_
13. Building Construction Type (e.g. Frame, joisted masonry, etc.): \_\_\_\_\_
14. Number of Stories: \_\_\_\_\_
15. What business/home/land/street is next to your office/building? Front \_\_\_\_\_  
Right \_\_\_\_\_ Left \_\_\_\_\_ Rear \_\_\_\_\_
16. Burglar Alarm Type: central local \_\_\_\_ station \_\_\_\_ Certificate #: \_\_\_\_\_
17. Fire Protection Type (e.g. sprinklers, fire alarm): \_\_\_\_\_
18. Annual payroll: \$ \_\_\_\_\_ # of Employees: \_\_\_\_\_ (Fill out the next page for WC)
19. Annual gross sales/income per location: \$ \_\_\_\_\_
20. Prior Insurance:

Insurance Company	Policy Number	Effective Date	Premium	# of Losses

21. Has your insurance been cancelled or non-renewed in the last 3 years: \_\_\_\_\_
22. If yes, explain: \_\_\_\_\_
23. Any leased or temporary employees? \_\_\_\_\_ Any volunteers? \_\_\_\_\_
24. Do any employees work out of their own home? Yes \_\_\_\_\_ No \_\_\_\_\_
25. Any Vacancies in building? Yes \_\_\_\_\_ N \_\_\_\_\_ (if yes, what percentage) \_\_\_\_\_
26. Liability Limits desired: (choose one)
  - \$1,000,000 per occurrence/\$2,000,000 Aggregate
  - \$2,000,000 per occurrence/\$4,000,000 Aggregate
27. Any other line of insurance required? Please list: \_\_\_\_\_
28. Any additional interest that requires proof of coverage? (landlord/building owner, clients):  
Loss Payee: \_\_\_ Mortgage: \_\_\_ Other: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_

**Please answer the following if content or building needs to be insured:**

29. Business Personal Property: Inventory Value\$ \_\_\_\_\_ Equipment Value \_\_\_\_\_
30. Building Value (if owner of building): \$ \_\_\_\_\_

\_\_\_\_\_  
Signature Title Date

Please return the completed form to help@ca-insurance.com or fax to 408-922-0700, if you have questions please call 408-922-0600.



## Workers' Compensation (WC) Insurance Questionnaire

Do you give out W2? Yes \_\_\_\_ No \_\_\_\_ If no, stop. You do not need WC insurance.

### Location Information:

Business Location	Physical Address	# of Stories	Building Construction Type
#1			
#2			
#3			

### Officer or Owner Information:

Location #	Name of Officer	SSN# (can be provided later)	% of Ownership	Decline WC coverage?	Annual Payroll

### Workers' Compensation Policy Information of the Current and Last Four Years:

Insurance Company	Policy Number	Effective Date	Premium	# of Claims

Has insurance ever been cancelled or non-renewed in the past 4 years: Yes \_\_\_\_ No \_\_\_\_

If yes, why: \_\_\_\_\_

### Workers and Work Place Information:

Location #	Payroll Classes or Work Description (e.g. 8810 for clerical)	Payroll Amount (Exclude Officer)	Number of Employee	
			Full-time	Part-time

- Hours of Operation \_\_\_\_\_
- Health insurance provided to employees? \_\_\_\_\_
  - If yes, Name of health insurance company \_\_\_\_\_
  - What is the % of health insurance premium paid by employee? \_\_\_\_\_
  - How many % of employees participate? \_\_\_\_\_
- Paid sick leave? Yes \_\_\_\_ No \_\_\_\_
- Paid vacation? Yes \_\_\_\_ No \_\_\_\_
- Employees travel out of state? Yes \_\_\_\_ No \_\_\_\_
- Group transportation provided? Yes \_\_\_\_ No \_\_\_\_
- Employee starting hourly wage: \$ \_\_\_\_\_ Average hourly wage: \$ \_\_\_\_\_
- Number of employee over 60 \_\_\_\_\_ or less than 16 \_\_\_\_\_
- If your company uses subcontractors, are any workers paid by 1099? Yes \_\_\_\_ No \_\_\_\_
  - (If yes, give % of work subcontracted) \_\_\_\_\_
  - If yes, are certificates of insurance required for all subcontractors? Yes \_\_\_\_ No \_\_\_\_
- Written safety program in the company? Yes \_\_\_\_ No \_\_\_\_
  - If yes, what is the program? \_\_\_\_\_
- Does your company utilize a return-to-work (RTW) program? Yes \_\_\_\_ No \_\_\_\_
- Maximum weight lifted manually: \_\_\_\_\_ lbs.
- How many vehicles does the company own? \_\_\_\_\_
  - What is the radius of travel? \_\_\_\_\_ and how often is the travel? \_\_\_\_\_
  - How many drivers? \_\_\_\_\_
  - Is MVR check at least annually? Yes \_\_\_\_ No \_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

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