



CLAIMS ADJUSTER INSURANCE PACKAGE – QUOTE REQUEST
(complete only what applies to your firm and coverage requested)

General Information

Named Insured: _____ DBA: _____
 Address: _____
 Contact Name: _____ Phone: _____
 Website: _____ Email: _____

Business Information

Year business Established: _____ Years of experience: _____ Total Gross Fees: _____
 Gross Fees Percentage: _____ Ind. Adjuster _____ Public Adjuster _____ Damage Appraisals _____ Other
 Adjusting Percentage: _____ Residential _____ Commercial _____ Industrial _____ Other: _____
 Office Area (SQFT) _____ Adjusters Payroll: _____ Office Payroll: _____
 Total No. of Employees: _____ No. Lic. Adjusters: _____ Any Auto Owned? Yes No
 Check all that applies: Prior/Currently Insured Prior Policy Cancelled / Non-renewed Any Prior Claims
 Current Expirations Dates: General Liab.: _____ Workers Comp: _____ Property: _____ Other: _____

Coverage Requested

Professional Liability General Liability Workers Comp. Property Automobile Cyber EPLI Bond

Professional Liability (complete if Professional Liability is requested)

Has the name or ownership of the firm changed or has any other business been purchased, merged, or consolidated with the firm within the last 5 years? Yes No
 Is the firm owned or controlled by any other firm or individual? Yes No
 Any owner or officer own, engage in, operate, manage, or act as a director or officer of any other business? Yes No
 During the past five years, has any claim been made or suit brought against the applicant, its predecessor(s) in business or any of its present or former owners, partners, directors, employees, or independent contractors? Yes No
 Is any owner, partner, director, or independent contractor aware of any circumstance, allegation, contention, or incident which may result in a claim being made against the applicant, its predecessor(s) in business or any of its present or former partners, owners, officers, directors, or independent contractors? Yes No
 Has any license held by the firm or any individual ever been suspended or revoked by any authority? Yes No
 Does the applicant:
 Negotiate or place structured settlements? Yes No
 Perform services as a third-party administrator? Yes No
 Supervise litigation? Yes No
 Provide claims investigation services? Yes No
 Derive more than 25% of their receipts from adjusting workers' comp. or medical malpractice claims? Yes No
 Have authority to settle on behalf your client/carrier? (If yes: Max. Amount: _____) Yes No
 Do you have authority to deny claims on behalf of your client/carrier? Yes No
 Use independent contractors Yes No
 Has similar professional liability in force? (if yes, Carrier: _____ Exp. Date: _____) Yes No

Commercial Property (Complete if Property is requested)

Coverage Requested: Building: _____ Contents: : _____ Construction Type: Frame JM MNC FR
 Update years (if know) _____ Electrical _____ Plumbing _____ Roof _____ Type of premises: Residential Commercial