



*Please visit www.allrisks.com/submit-a-risk or contact your current All Risks, Ltd. producer to submit applications.

ELEVATOR CONTRACTORS APPLICATION SUPPLEMENT
(To be used with Acord Application)

- Proposed First Named Insured & Other Named Insured(s): _____
- Mailing Address: Street _____ City _____ County _____ State _____ ZIP Code _____
- Contact Name: _____ Web Site Address: _____

Contact for Inspection/Audit:	Name:
	Phone No.:
- Applicant is: Individual Partnership Corporation LLC Joint Venture
 Other (specify): _____
- Proposed Effective Date: From: _____ To: _____

BUSINESS INFORMATION

- Number of Years in Business: _____ Number of Years Experience: _____
- Is business licensed? Yes No
- Percentage of work for the following:
 Inspection _____ % Service _____ % Repair _____ %
 Commercial _____ % Residential _____ % Private Dwellings? Yes No
 Describe operations: _____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 9. Any 24 hour emergency service? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Any work performed in/on: | | |
| (a) Any kind of escalators? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, percentage of operations: _____ % | | |
| (b) Densely populated buildings? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, percentage: _____ % | | |
| (c) Buildings in excess of 8 stories? Percentage: _____ % | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Hotels | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Public Transit Stations | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Hospitals Percentage: _____ % | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Any Handicap lifts installed for the Handicapped? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Any patient lift installations? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, technicians are: <input type="checkbox"/> Factory trained <input type="checkbox"/> Certified by the manufacturers | | |
| Provide a list of manufacturers the insured does work for. | | |

- Provide payrolls for installation and repair work for the past 3 years:

Year	Payrolls

14. Provide 3 largest jobs performed in the past 12 months:

Description	Cost

15. Provide current work: _____

16. Are subcontractors utilized? Yes No
 If yes, types of work subcontracted: _____

17. Does the insured utilize standard contracts when hiring subcontractors utilizing an Indemnity Clause?

18. Provide subcontracted costs.
 Do all subcontractors carry equal limits and our insured is named as Additional Insured?

19. Any losses in excess of \$10,000? Attach 3 years loss history.
 If yes, explain: _____

FRAUD STATEMENTS

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

LOUISIANA and MAINE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Refer to the Core Application for all Fraud Statements.

IMPORTANT NOTICE

DECLARATION

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SIGNATURES

Applicant Signature	Title	Date
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Producer Signature	Date
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Agent Name and Address _____