

Commercial Insurance Proposal



Date

General

Insured Name:	<input type="text"/>		
Registration No:	<input type="text"/>	VAT Number:	<input type="text"/>
Physical Address:	<input type="text"/>		
		Postal Code:	<input type="text"/>
Postal Address:	<input type="text"/>		
		Postal Code:	<input type="text"/>
Telephone Number:	<input type="text"/>	Fax Number:	<input type="text"/>
Email Address:	<input type="text"/>	Website Address:	<input type="text"/>
Contact Person:	<input type="text"/>	Cell Number:	<input type="text"/>
Number of years in Business:	<input type="text"/>	Name of Owner Director:	<input type="text"/>
Have you previously operated in a different name:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
Have you ever been liquidated or sequestered:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>

Premises Details

Construction of Premises

Walls:	<input type="text"/>
Roof:	<input type="text"/>

Security at Premises

Doors:	<input type="text"/>
Windows:	<input type="text"/>
Linked Alarm:	<input type="text"/>
Name:	<input type="text"/>
Guards:	<input type="text"/>
CCTV:	<input type="text"/>
Other:	<input type="text"/>

Underwriting Information

Fire Extinguishers:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
Fire Hose Reels:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
Fire Hydrants:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
Sprinkler System:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
Pallets used:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>
LP Gas used:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="text"/>

Initial Here

Present | Previous Details

1.	Insurer Names and Policy Numbers:				
2.	Has any Insurer at any time ever Declined Cancelled Increased Terms	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	If Yes, Why?				
3.	Has any Insurer at any time ever rejected any claim:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	If Yes, Why?				

Previous Loss | Claims History

Type of Loss Claim	Year	Amount	Insurer