

Circuit Workout Application

Agency Name _____ # _____ Quote Only Issue Policy
 Producer _____ Effective Date _____
 Additional Coverages*: Auto Workers Comp.** Umbrella EPLI(Stand Alone) None
 *Note: A separate ACORD or NSI application must be completed for each of these coverages.
 ***Note: Workers Compensation is not applicable in Kentucky, Michigan and Ohio.

APPLICANT INFORMATION:

Applicant's Name _____ Mailing Address _____
 _____ City _____ State _____ ZIP _____
 Contact Person _____ Phone # _____
 Applicant is a: Individual Partnership Corporation
 Other (specify) _____

PREMISES INFORMATION

Location #	Building #	Street, City, County, State, ZIP

Answer all of the following questions:

- A. How many years has the applicant been in business? _____ years.
- B. Does applicant perform any other operations? Yes No
 If yes, provide description: _____
- C. Does the applicant own any buildings? Yes No
 - 1. Yes No Does the applicant lease any part of any of the building(s) at this location to others?
 *If yes, a copy of the certificate of insurance for the leased area is required.
 - 2. _____ What is the total square footage leased to others?
 - 3. _____ Total number of apartments at this location? *
 *A copy of the lease agreement and the HO-4 is required if coverage is bound.

Annual Gross Sales:
 Number of Members:
 Cost of all equipment:

Prior Insurance Information

Prior Carrier	Eff./Exp. Date	Policy Number	Policy Premium

Loss History Check here if there are no prior claims.

Date of Occurrence	Description of Claim	Amount Paid	Claim Status
			<input type="checkbox"/> Open <input type="checkbox"/> Closed
			<input type="checkbox"/> Open <input type="checkbox"/> Closed
			<input type="checkbox"/> Open <input type="checkbox"/> Closed
			<input type="checkbox"/> Open <input type="checkbox"/> Closed

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LIABILITY SECTION

1. PER OCCURRENCE/AGGREGATE LIMITS

Limit options: \$300,000/600,000, \$500,000/1,000,000, \$1,000,000/2,000,000, \$1,000,000/3,000,000

2. SCHEDULE OF HAZARDS

Table with 4 columns: Classification, Class Code, Premium Base, Exposure. Rows include Circuit Workout Machines (1-10 machines) and Circuit Workout Machines (each additional machine).

4. Tanning Beds: Does applicant provide any tanning services?

Yes/No checkboxes

- A. What percentage of UVB radiation do the tanning beds produce?
B. Are all customers given information about the types of rays and the potential sensitivity?
C. Are records kept on each tanning customer for each visit and exposure time?
D. Are eye protective goggles required for all users?
E. Does an employee sanitize beds after every use?
F. Does the customer sign a waiver of liability before using tanning services? If yes, provide a copy of the waiver.

PROPERTY COVERAGES/BUILDING INFORMATION: Property coverage desired?

Yes/No checkboxes

Location # Building #

Form section for property details including construction type (Frame, Masonry, etc.), square footage, stories, improvements, and deductible options.

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Form section for property details including construction type, square footage, stories, improvements, and deductible options.



WORKERS COMPENSATION

- 1. Do you need Workers Compensation? (If yes, please contact Patrick Schatz.)
- 2. If yes, Annual Payroll for employees:

Yes No

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I have read the above questions and I hereby declare to the best of my knowledge and belief that all of the foregoing statements are true and that these statements are offered as an inducement to the company to issue the policy for which I am applying.

NOTICE: PLEASE READ BEFORE SIGNING!

In order to underwrite the insurance applied for above, an investigation consumer report may be requested and made, including information as to the character of the applicant for insurance and the persons to be insured under the policy applied for, their general reputations, business characteristics and credit standing. You are advised that you may make a request within a reasonable time after receipt of this Notice for a disclosure by **West Bend Mutual Insurance Company** of the nature and scope of the investigation requested.

Fraud Warning

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Ohio: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

All Other States: Any person who knowingly conceals or provides materially false, incomplete, or misleading information on an application or concerning a claim to an insurance company for the purpose and intent of defrauding the company, may be guilty of insurance fraud in violation of state law. Penalties may include imprisonment, fines, or denial of insurance benefits.

Date _____ Time _____ Applicant's Signature _____

Agency Name and Producer's Signature _____

For Questions please call or email Patrick Schatz: 847-356-1520 x117. pschatz@schatzins.com