BUSINESS OWNERS/WORKERS COMP INDICATION REQUEST FORM

Paragon Underwriters, Inc.
7115 Orchard Lake Road, #500
West Bloomfield, MI 48322
Tel: 800.727.0001
Fax: 248.851.1205
www.ParagonUnderwriters.com

Complete this form, including your signature, and fax it to 248-851-1205 for quotes on Business Owners and/or Workers' Compensation Insurance.

GENERAL FIRM INFORMATION

Firm Name ______________________ Year Business Started ____________
Mailing Address ______________________ City ____________
County ____________ State ________ Zip ________ E-Mail ____________
Contact Person ____________ Telephone ____________ Fax ____________
Individual ☐ Corporation ☐ Partnership ☐ Other: ____________
Do you own any other Business? Yes ☐ No ☐ If Yes, Type : ____________
Annual Sales $____________

BUSINESS OWNERS INSURANCE

(The following information is needed for each office location whether you are a tenant or a building owner.)

Requested Effective Date ____________ Location Address (if different) ____________
Tenant ☐ Building Owner ☐ Year Built ________ Does the building have a sprinkler system? Yes ☐ No ☐
Estimated Year of Last Update On : Heating ________ Plumbing ________ Roof ________ Electrical ________
Building Construction ____________ Number of Stories ________ Area Occupied (sq. ft.) ________
Building Value (If Owned) ____________ Business Personal Property Limit ____________
Deductible: $250 ☐ $500 ☐ $1,000 ☐ Liability Limits: $1,000,000/$2,000,000 ☐ $2,000,000/$4,000,000 ☐
Fire &/or Burglar Protection (check all that apply) Central Station Fire Alarms ☐ Central Station Burglar Alarm ☐
Building Vacancy Rate 0% ☐ <10% ☐ 10-20% ☐ >20% ☐ Has your firm ever filed bankruptcy? Yes ☐ No ☐
Are you currently Insured? Yes ☐ No ☐ If Yes, Carrier Name: ____________
Has your firm ever been cancelled/ non-renewed/ declined for business owners coverage? Yes ☐ No ☐
Has your firm had any claims in the past 5 years? *Yes ☐ No ☐
*If so, provide the date of loss, amount paid, and details of the loss.

WORKERS COMPENSATION INSURANCE

Requested Effective Date ____________

Federal Identification Number

____

Are you currently insured? Yes ☐ No ☐
-If Yes, what is your Experience Mod? ________

Employee Class	# of Employees	Annual Payroll
Attorneys		
Clerical Staff		

Do you wish to exclude any owners/partners/officers? Yes ☐ No ☐ If so, please do not include their payroll in the table above.
Has your firm had any claims in the past 5 years? *Yes ☐ No ☐
*If so, provide the date of loss, amount paid, and details of the loss.

By signing below, I represent that the statements above are true to the best of my knowledge. I also agree to accept receipt of a premium indication from Paragon Underwriters Inc., by fax, e-mail or postal mail.

____________ ____________ ____________
Authorized Signature Printed Name Date