Surplus Insurance Brokers Agency Inc.

Call 800-342-5706
Fax 800-578-7758 ▪ www.surplusins.com
Email quotes: submit@surplusins.com
P O Box 749, South Bend IN 46624-0749

PERSONAL LIABILITY UMBRELLA APPLICATION

Applicant's Name: _____
Mailing Address: _____
_____
Garaging Address: _____
(If different) _____
_____

Agent's Name: _____
Address: _____
City: _____
Telephone: ___-___-____ Fax: ___-___-____
Agent's Code: _____
Agent/Broker License No.: _____

PROPOSED EFFECTIVE DATE: From: _____ **To:** _____
12:01 A.M., Standard Time, at the address of the Applicant

COVERAGE AND LIMIT INFORMATION

Coverages		Premiums		Calculations
Application for Primary Umbrella ☐		Basic	$	
Application for Excess Umbrella ☐		Residences	$	
Policy Amount	Retention	Automobiles	$	
$ MILLION	$	Recreational Vehicles	$	
		Watercraft	$	
		Total	$	

PRIMARY POLICY INFORMATION Primary Carrier must be B+V Rated or Better by AM Best.
(Attach separate sheet, if necessary.)

Type of Policy	Company/Policy Number	Policy Period	Limits of Liability Bodily Injury	Property Damage
CPL/Homeowners		to		
Watercraft		to		
Automobile/Rec Vehicle		to		
		to		
Uninsured Motorists		to		
Underinsured Motorists		to		
Other Property		to		
Other (Explain)		to		
Underlying Umbrella		to	$	MILLION

REAL ESTATE

List all owned, leased or occupied residences, buildings, farms, vacant land, etc.
(Attach separate sheet, if necessary.)

NO.	Location	Description	No. Units/ Acres	Year Built	Occupancy
1					
2					
3					

AUTOMOBILES, RECREATIONAL VEHICLES, VEHICLES, MOTOR HOMES, MINIBIKES, ETC.

List all vehicles owned, leased or furnished for regular use.
(Attach separate sheet, if necessary.)

No.	Year	Vehicle Type, Make And Model	No.	Year	Vehicle Type, Make And Model
1			6		
2			7		
3			8		
4			9		
5			10		

OPERATOR INFORMATION

List All members of household and all operators of vehicles/watercraft.
(Attach separate sheet, if necessary.)

No.	Name	Driver's License Number	ST	Date of Birth	Vehicle, Craft, % Use, Etc.	Accidents/ Violations Prior Three Years	Number of Accidents Each			
							At fault	Not at fault	No. of major	No. of minor
1						☐ Yes				
2						☐ Yes				
3						☐ Yes				
4						☐ Yes				
5						☐ Yes				
6						☐ Yes				

WATERCRAFT

List all watercraft owned, leased, chartered or furnished for regular use.
(Attach separate sheet, if necessary.)

No.	Year	Type, Manufacturer and Model	Length	Horse-Power	Maxi-mum Speed	Over 50 MPH	Waters Navigated (Fresh or Salt)
1			FT			☐	
2			FT			☐	
3			FT			☐	

EMPLOYMENT

	Occupation 0f Each Household Member	Employer's Name And Address. If not employed, indicate for each.
1		
2		
3		
4		
5		
6		

PRIOR EXPERIENCE

Has any loss occurred on any primary or excess policy, exceeding $5,000, during the last five (5) years? ☐ Yes ☐ No If Yes, you must provide complete details of event including amounts paid or reserved below.	Amount Paid	Open or Closed

Prior Carrier And Policy Number:

GENERAL INFORMATION

No.	Explain All "Yes" Responses in Remarks	Yes	No	No.	Explain All "Yes" Responses in Remarks	Yes	No
1	Any aircraft owned, leased, chartered or furnished for regular? If Yes, include in remarks if excluded in policy.	☐	☐	8	Do you employ any residence employees?	☐	☐
2	Any driver convicted for any traffic violations? (Last 3 years)	☐	☐	9	Any non-owned property exceeding $1,000 in value, in your care, custody or control?	☐	☐
3	Any operator have a physical/mental impairment? If Yes, include operator number in remarks. (**Not applicable in Wisconsin)**	☐	☐	10	Any non-owned business and/or professional activities included in the primary policies?	☐	☐
4	Any premises, vehicles, watercraft, aircraft used for business?	☐	☐	11	Does any primary policy have reduced limits of liability or eliminate coverage for specific exposures? If Yes, include in remarks if excluded in policy.	☐	☐
5	Any premises, vehicles, watercraft, aircraft, owned, hired, leased or regularly used, not covered by primary policies?	☐	☐	12	Was any coverage declined, canceled, nonrenewed? (Last five [5] years) **(Not Applicable to Missouri Applicants)**	☐	☐
6	Do you engage in any type of farming operation?	☐	☐	13	Any motorcycles, mopeds or all terrain vehicles owned by insured (may be excluded)?	☐	☐
7	Do you hold any non-compensated positions?	☐	☐	14	Any other underwriting information of which Company should be aware?	☐	☐
REMARKS:				15	Are any business activities conducted from your residence or premises? If Yes, include in remarks if excluded in policy.	☐	☐

INSURANCE CANNOT BE CONSIDERED FOR BINDING UNLESS THIS APPLICATION IS SIGNED BY THE APPLICANT.

ATTESTATION, NOTICES AND FRAUD WARNINGS

PRIVACY POLICY

I have received and read a copy of the "Scottsdale Insurance Company Privacy Statement and Procedures." By submitting this application, I am applying for issuance of a policy of insurance and, at its expiration, for appropriate renewal policies issued by Scottsdale Insurance Company and/or other members of the Scottsdale group of insurance companies. I understand and agree that any information about me that is contained in, or that is obtained in connection with, this application or any policy issued to me may be used by any company within the Scottsdale group to issue, review, and renew the insurance for which I am applying.

FAIR CREDIT REPORTING ACT NOTICE

This notice is given to comply with Federal Fair Credit Reporting Act (Public law 91-508) and any similar state law which is applicable as part of our underwriting procedure. A routine inquiry may be made which will provide information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to nature and scope of the report will be provided.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties.

ATTESTATION

I have read the foregoing and agree that it is true and complete to the best of my knowledge and that this policy, if issued, and all renewals thereof, is to be issued in reliance upon this information, unless a change in information is supplied by me. I understand that signing this application does not bind me to accept this insurance nor does it bind the company to issue a policy to me.

APPLICANT SIGNATURE: _____ TIME: _____ DATE: _____

PRODUCER'S SIGNATURE: _____ DATE: _____

SCOTTSDALE INSURANCE COMPANY®

MEDICAL STATEMENT

DATE (MM/DD/YY)

PRODUCER	INSURED'S NAME	
	☐ NEW ☐ RENEWAL	POLICY NUMBER

DRIVER INFORMATION

DRIVER'S NAME	DATE OF BIRTH	AGE	SEX		
	FAMILY PHYSICIAN'S NAME AND ADDRESS			YEARS UNDER PHYSICIAN'S CARE	DATE OF LAST VISIT

DRIVER MEDICAL HISTORY

EXPLAIN ALL "YES" RESPONSES IN REMARKS – INCLUDE QUESTION NUMBER AND EXPLANATION

EYESIGHT

1. Has Insured lost use/sight of either eye? ☐ Yes ☐ No
2. Is peripheral (side) vision restricted? ☐ Yes ☐ No
3. Does Insured have or have you ever had cataracts? ☐ Yes ☐ No
4. Are sight deficiencies corrected by glasses/contacts? ☐ Yes ☐ No
   Uncorrected Vision: _____/_____
   Corrected Vision: _____/_____
5. Date of last examination: _____

HEARING

6. Is Insured able to hear normal conversation level? ☐ Yes ☐ No
7. If no, is hearing aid used? ☐ Yes ☐ No

HEART

8. Has Insured ever been treated for heart disease? ☐ Yes ☐ No
9. Has Insured ever had a heart attack? ☐ Yes ☐ No
10. Does Insured have a pacemaker? ☐ Yes ☐ No
11. Medication/dosage used: _____
12. When was last treatment or check-up? _____

LIMBS

13. Has Insured lost the use of an arm or leg? ☐ Yes ☐ No
14. Does car have special controls? ☐ Yes ☐ No

DIABETES

15. Is Insured being treated for diabetes? ☐ Yes ☐ No
    A. Latest blood sugar treat date: _____
    B. Medication/Dosage used? _____

EPILEPSY

16. Has Insured ever been treated for epilepsy? ☐ Yes ☐ No
    A. If yes, kind and date of last seizure: _____
    B. Medication/Dosage used: _____

BLOOD PRESSURE

17. Has Insured ever been treated for high blood pressure? ☐ Yes ☐ No
    A. If yes, date of last treatment: _____
    B. Last reading: _____
    C. Medication/Dosage used: _____

MISCELLANEOUS

18. Has Insured ever been treated or received medication for any neurological mental or emotional problem? ☐ Yes ☐ No
19. Has Insured ever been treated or received medication for any neuromuscular disease (Muscular Dystrophy, Multiple Sclerosis, Cerebral Palsy, etc.)? ☐ Yes ☐ No
20. Are there any restrictions posted on Insured's Drivers License other than glasses? ☐ Yes ☐ No
21. Indicate date of last treatment, if applicable:
    A. Convulsions: _____
    B. Fainting Spells: _____
    C. Loss of Equilibrium: _____
    D. Alcohol/Drug Abuse: _____
    E. Mental/Emotional Illness: _____
    F. Complete Physical Examination: _____
22. Is Insured under the care of a physician for any condition not mentioned above? ☐ Yes ☐ No

REMARKS

_____

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS ARE TRUE.

_____	_____	_____
Insured's Signature	Physician's Signature	Date