



**CONTRACTOR'S
EQUIPMENT
APPLICATION**

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

1. First Named Insured _____
The first Named Insured is responsible for premium payment, cancellation, and changes - refer to policy wording.

2. Other Insured(s) _____

3. Mailing Address _____
Street City County State ZIP Code

4. Effective Date Desired _____ Term Desired _____

5. **PRIOR INSURANCE CARRIER AND LOSS HISTORY FOR THE PAST THREE YEARS**

Year	Carrier/Policy Number/Premium	Coverage	Losses	Amount	Description of Losses (Use separate sheet if necessary)

Missouri Applicants: **DO NOT** answer this question.
Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?
 No Yes - If so, give name of company, date, and reason.

6. Years in Business _____ Years of Experience _____

7. Loss Payable _____
Street City County State ZIP Code

COVERAGE

8. Named Causes of Loss Named Causes of Loss Including Theft All Risk
 Other _____

9. Deductible: \$250 \$500 \$1,000 Other _____

SCHEDULE OF EQUIPMENT

10.

Unit No.	Year of Unit	Unit Description	Manufacturer	Model	Serial No.	Value or Limit of Liability
1						
2						
3						
4						
5						

TERMINAL INFORMATION

11.

Address (Street, City, State, Zip)	Construction	Fire Cnts. Rate	Maximum Value
1			
2			
3			
4			
5			

UNDERWRITING INFORMATION

- 12. Type of Contracting (i.e., excavation, mining, logging) _____
- 13. If equipment is not inside, is lot fenced? Yes No Lighted? Yes No
- 14. Is lot attended at all times? Yes No Other protections _____
- 15. Percentage of time equipment is on job site _____%; at terminal _____ %
- 16. Is fire extinguishing equipment maintained on each piece of equipment? Yes No
- 17. Describe theft safeguards at job sites (eg. alarms, I.D. numbers used, special locks) _____

- 18. Have any payments been delinquent in the last 6 months on equipment to be insured hereunder? Yes No
If yes, explain: _____

IMPORTANT NOTICE

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

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment.

Agent

Address

Date

Insured's Signature

Additional Signature if applicable

Date