# COMMERCIAL QUESTIONNAIRE

## COMPANY INFORMATION

**Company Legal Name:** _____ **Federal Tax ID#:** _____ **Year Established:** _____

**DBA:** _____ **SIC:** _____ **Multiple Locations:** Yes / No

**Business Address:** _____ **City:** _____ **Zip:** _____

**Business Phone:** (____) _____ **Business Fax:** (____) _____

**Contact Person:** _____ **Title:** _____

**Contact Phone:** (____) _____ **E-Mail:** _____

**Type of entity:** (Check One) ___ C Corp ___ S Corp ___ Limited Liability Company ___ Partnership ___ Sole Proprietorship

**Type of Business** (Please describe your business operation)**:** _____

## GENERAL LIABILITY

*Complete the information below of forward a copy of your current policy declaration page*

**Gross Revenue:** _____

**Current Limits:**

General Aggregate: _____ Products & Completed Operations: _____ Each Occurrence: _____

Personal & Advertising Injury: _____ Medical Expenses: _____ Employee Benefit: _____

Damage to Rented Premises: _____

## PROPERTY

*Please include building information for each location, use additional pages if necessary*

**Current Limits:**

Business Income: _____ Business Personal Property: _____ Computer/Electronic Equipment: _____

Location #1: _____ Address: _____ ☐Own ☐Tenant

Year Built: _____ # Stores: _____ Construction Type (i.e.: Steel, Wood, Concrete): _____

Total Building Square Footage: _____ Occupied Square Footage: _____

**Building Improvements:**

Wiring Year: _____ Plumbing Year: _____ Roofing Year: _____ Heating Year: _____

**Exposure:** What Surrounds The Building?

Right Side: _____ Left Side: _____ Rear: _____

**Alarms/Protection:**

Burglar: _____ Company: _____ Guard/Watchman: _____ Fire: _____ Sprinklers: _____

**SEND COMPLETED FORM TO:**
**Fax (310) 755-6086 or**
**Email:**
**info@CloudMinturn.com**

Cloud, Minturn Associates, LLC
dba: CMA Insurance Services
CA License #0735758

Phone (310) 316-3662
Fax (310) 755-6086
E-Mail: Info@CloudMinturn.com

# COMMERCIAL QUESTIONNAIRE

## UMBRELLA

**Current Limits:** _____

## COMMERCIAL COVERAGE HISTORY

**Policy Year:** _____ **Insurance Carrier:** _____ **Policy Number:** _____

**Policy Year:** _____ **Insurance Carrier:** _____ **Policy Number:** _____

**Policy Year:** _____ **Insurance Carrier:** _____ **Policy Number:** _____

## VEHICLES

*Use Additional Pages If Necessary*

**Current Limits**

Liability: _____ Property Damage: _____ Medical Payments: _____ # Of Vehicles _____

Collision: _____ Compensation: _____ Deductible: _____ # Of Drivers: _____

**Vehicle #1** Make: _____ Model: _____ Year: _____ Vin#: _____

**Overall Use:** ☐Pleasure ☐Retail ☐Service Mileage To Work: _____ Garaging Zip Code: _____

**Driver Information** Name: _____ Date Of Birth: _____ Driver's License #: _____ State: _____

**Vehicle #2** Make: _____ Model: _____ Year: _____ Vin#: _____

**Overall Use:** ☐Pleasure ☐Retail ☐Service Mileage To Work: _____ Garaging Zip Code: _____

**Driver Information** Name: _____ Date Of Birth: _____ Driver's License #: _____ State: _____

**Vehicle #3** Make: _____ Model: _____ Year: _____ Vin#: _____

**Overall Use:** ☐Pleasure ☐Retail ☐Service Mileage To Work: _____ Garaging Zip Code: _____

**Driver Information** Name: _____ Date Of Birth: _____ Driver's License #: _____ State: _____

## VEHICLE COVERAGE HISTORY

**Policy Year:** _____ **Insurance Carrier:** _____ **Policy Number:** _____

**Policy Year:** _____ **Insurance Carrier:** _____ **Policy Number:** _____

**Policy Year:** _____ **Insurance Carrier:** _____ **Policy Number:** _____

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