



8722 S. Harrison St. Sandy, UT 84070  
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### GLASS INSTALLATION APPLICATION

**A. General Information**

Proposed Effective Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Physical Location of Business (if different): \_\_\_\_\_

Population within 50 miles: \_\_\_\_\_

**Other Locations Used:**

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list any other names the business is or has been known by: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Producer's Name: \_\_\_\_\_

Detailed description of business activities (specifically, and by location): \_\_\_\_\_

Applicant is:  Individual  Corporation  Partnership  Joint Venture  Other: \_\_\_\_\_

Is this a new business?  Yes  No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: \_\_\_\_\_

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: \_\_\_\_\_

Annual Payroll: \$ \_\_\_\_\_ Total Number of Employees: \_\_\_\_\_ Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: \_\_\_\_\_

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services?  Yes  No

If yes, please tell us:

Employee Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Business Telephone No.: \_\_\_\_\_

Fax: \_\_\_\_\_ Years with Company: \_\_\_\_\_

Employee's Responsibilities: \_\_\_\_\_

**B. Insurance History**

Who is your current insurance carrier (or your last if no current provider)? \_\_\_\_\_

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor ever had a claim?  Yes  No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy?  Yes  No

If yes, please explain: \_\_\_\_\_

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?  Yes  No

If the standard markets are declining placement, please explain why: \_\_\_\_\_

**C. Other Insurance**

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	2	3
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

**D. Desired Insurance**

Per Act/Aggregate OR Per Person/Per Act/Aggregate

<input type="checkbox"/>	\$50,000/\$100,000	<input type="checkbox"/>	\$25,000/\$50,000/\$100,000
<input type="checkbox"/>	\$150,000/\$300,000	<input type="checkbox"/>	\$75,000/\$150,000/\$300,000
<input type="checkbox"/>	\$250,000/\$1,000,000	<input type="checkbox"/>	\$100,000/\$250,000/\$1,000,000
<input type="checkbox"/>	\$500,000/\$1,000,000	<input type="checkbox"/>	\$250,000/\$500,000/\$1,000,000
<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____

**Self-Insured Retention (SIR):**  \$1,000 (Minimum)  \$1,500  \$2,500  \$5,000  \$10,000

**E. Business Activities**

1. Business Operations Breakdown: Identify percentage of your mirrors and windows business operations:

Commercial	%
Commercial – over 2 stories	%
Residential –single family or twin home- not over 2 story structure	%

2. Identify the percentage of your business operations:

Commercial glass	%
Private passenger auto glass	%

3. Estimate total gross receipts from mirrors and windows operations only, including materials, for next 12 months:

Commercial	\$
Residential	\$

4. Estimated gross receipts from auto glass operations only, including material and repair services for next 12 months:

Commercial	\$
Residential	\$

5. Estimated gross receipts from auto glass operations only, including material and repair services for next 12 months:

Commercial	\$
Residential	\$

6. Total Gross Annual Receipts from all business operations, windows, mirror and auto glass and product sales, retail sales or other service work: \$ \_\_\_\_\_

7. Total Gross Annual Receipts from new construction window, sales and installation contractor services: \$ \_\_\_\_\_

8. "Total Gross" Annual Receipts from new construction mirrors sales and installation operations only: \$ \_\_\_\_\_

9. What percent of your total gross receipts is received from sub-contracted work you perform for other contractors? \_\_\_\_\_%

10. What percentage of work is repair of broken windows? \_\_\_\_\_%

11. What percent of work is repair of broken mirrors? \_\_\_\_\_%

12. Does your business:

- a. Fabricate Glass?  Yes  No
- b. Have pneumatic or electrical cutout devices?  Yes  No
- c. Lease or rent equipment to others?  Yes  No

If yes, what? \_\_\_\_\_

- d. Lease or rent equipment from others?  Yes  No

If yes, what? \_\_\_\_\_

- e. Distribute or sell materials or supplies for installation by others?  Yes  No

If yes, show annual gross receipts from distribution or sale: \$ \_\_\_\_\_

- f. Do you hire sub-contractors?  Yes  No

If yes:

- 1. Do you require certification and evidence of liability insurance from sub-contractors?  Yes  No

- 2. Do you require evidence of Workers Compensation insurance from sub-contractors?  Yes  No

- 3. Gross annual receipts from work sub-contracted out: \$ \_\_\_\_\_

- 4. Explain type of work you sub-contracted out: \_\_\_\_\_

\_\_\_\_\_

**REPRESENTATIONS AND WARRANTIES**

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: \_\_\_\_\_

Dated: \_\_\_\_\_

Applicant:

Agent/Broker:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name