



Dallas
P: (972) 789-1962
F: (972) 789-1967

Houston
P: (281) 759-4855
F: (281) 759-7245

hullandco-texas.com

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

General

1. Applicant: _____
2. Mailing Address: _____
3. Contact Name: _____
4. Applicant is: Individual Partnership Corp Other _____

Eligibility

	Decline	Submit	Eligible
1. Are there more than 100 units?		Yes	No
2. Any locations in Alaska or Louisiana?	Yes		No
3. Are all units owned by the applicant?		No	Yes
4. Any student renters?	Yes		No
5. Is the applicant the developer or builder of the building the units are in?	Yes		No
6. Is any unit used as the applicants primary residence?	Yes		No
7. Any aluminum wiring?	Yes		No
8. Is all wiring connected to circuit breakers?	No		Yes
9. Are all units equipped with smoke detectors and fire extinguishers?	No		Yes

Locations

Unit Number	Address	A = # of Annual Units S = # Seasonal Units
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

(Attach separate sheet of paper if more than 10 locations)

Commercial Liability/Property Coverages

Limits of Liability requested:
100/200 300/600 500/1Mil 1Mil/2Mil
Limits include Loss Assessment \$2500 per unit/\$25,000 aggregate

Property Coverages Requested Yes No

Coverage includes:
Improvements and Betterments \$5,000 per unit/\$50,000 aggregate
Loss of Rents \$6,000 per unit/\$50,000 aggregate

FRAUD STATEMENT: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

THE STATE OF NEW YORK REQUIRES THAT WE HAVE THE NAME AND ADDRESS OF YOUR (INSURED'S) AUTHORIZED AGENT OR BROKER.
NAME OF AUTHORIZED AGENT OR BROKER: _____
ADDRESS: _____
MAIL COMPLETED
APPLICATION THROUGH
LOCAL AGENT OR BROKER TO: