

quote no. _____

The information below has been entered into an on-line database system and will be utilized to complete an on-line application on your behalf. Please, make any necessary corrections directly on this form and return this form to your broker

Instructions:

- Carefully review all information contained in this document and the Facility/Storage Tank Inventory Supplemental Worksheet(s)
- Make any necessary corrections directly on the documents.
- Once you have completed your review, sign and date page 2 of this document.

Insured's Name: _____

Address: _____

City: _____

State: _____

Country: United States

ZIP: _____

Telephone #: _____

Email Address: _____ (not a mandatory field)

Is the Insured purchasing this coverage to satisfy financial responsibility requirements? YES NO

Any Additional Insureds to be listed on the Policy? YES NO
(If yes, please identify the Additional Insured's here.):

Effective Date of Coverage _____ (Expiration Date will be 1 year from effective date)

Retroactive Date _____ (max 10 year prior to desired effective date)

(Note that regardless of the retroactive date indicated above, a retroactive date of policy inception date shall apply to any tanks at facilities located in the State of Florida. If this policy has a facilities located in multiple states including If Florida, an endorsement to the policy shall be issued to that effect.)

Policy Limits :

UST Per Incident	_____	AST Per Incident	_____
UST Per Aggregate	_____	AST Per Aggregate	_____
Policy Aggregate	_____	Legal Defense Agg	_____

Per Incident Deductible: \$2,500
 \$5,000
 \$10,000
 \$25,000

Total Number of Facilities with Storage Tanks to be covered under this Policy _____

Total Number of USTs to be covered under this Policy _____

Total Number of ASTs to be covered under this Policy _____

- 1. Are any of the Insured's Facilities located in the state of Florida? YES NO
- 2. Are Single-Walled Storage Tanks (i.e., Bare Steel Tanks, Steel Tanks with Cathodic Protection, STIP ¾ Tanks or Tanks operating under ACT 100), with or without any form of tank lining, located at the insured's facilities in the State of Florida? (Only applicable if question 1 is answered yes) YES NO
- 3. Will any scheduled storage tank(s) be removed, closed or upgraded at any of the facilities for which coverage is sought under this policy within the next 18 months? YES NO
- 4. Are all of your storage tanks compliant with all applicable Federal, State, and local regulations? YES NO
- 5. Within the past five (5) years have any claims been made or legal actions (including any regulatory proceedings) been brought against any insured to be covered under this proposed insurance with respect to storage tanks or any other pollution conditions at any of the facilities where the storage tanks the insured(s) is (are) seeking coverage for are located? YES NO
- 6. Does the applicant have knowledge of pollution conditions actionable under current State or Federal regulations at any of the facilities where the tanks for which you are seeking coverage are located? YES NO
- 7. Within the past five (5) years, is any insured to be covered under this proposed insurance aware of any failed tank/piping integrity tests or any other negative monitoring system data for any of the Storage Tanks the insured(s) is (are) seeking coverage for? (leave unchecked if AST – only policy) YES NO
- 8. At the time of signing this application, is any insured aware of any circumstances that may reasonably be expected to give rise to a claim against any insured, related to Storage Tanks or other pollution conditions? YES NO

By signing below, the undersigned warrants and represents to the insurer that the information contained in this On-Line Data Confirmation Worksheet as well as the Facility/Storage Tank Inventory Supplemental Worksheet(s) attached hereto are true and correct, and that the undersigned has exercised its best efforts in verifying the accuracy of the information. The undersigned hereby acknowledges that the information contained herein is material to the decision of the insurance company to issue a policy, and that the issuance of a policy by the insurer is in reliance upon the sufficiency and accuracy of this information.

NOTE THAT YOUR CONFIRMATION OF THE ACCURACY OF THIS INFORMATION IS CRITICAL. ONCE THE DATA IS ENTERED INTO THE ELECTRONIC SYSTEM AND COVERAGE IS BOUND, NO CHANGES OR CORRECTIONS CAN BE MADE.

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act. Such an act is a crime and subjects such person to criminal and civil penalties.

Signature of Authorized Applicant X
Print Name
Title
Date