



Non-Profit Quick Indication Questionnaire

PLEASE INDICATE CURRENT / REQUESTED COVERAGE:

Table with 6 columns: Carrier, Limit, Retention, Currently Purchased? (Yes / No), Effective Date, Premium

1. Name & Address of Insured: Name _____
Address _____
City _____ State _____ Zip _____

2. Designated HR Contact: _____

3. Nature of Business / Operations: _____

4. Length of Operations: _____

5. Number of Employees : _____ Full-time _____ Seasonal
_____ Part-time _____ Volunteers

6. Annual Salary / Wages Expense: \$ _____

7. Total Assets \$ _____

8. Have any claims, losses, litigation, or proceedings that would fall within the scope of the proposed insurance occurred in the last five (5) years or has anyone knowledge of any circumstance which could reasonably give rise to a claim?
[] Yes [] No

If yes, please provide complete details in separate attachment giving names, dates, allegations, current status, and all costs incurred.

9. Other information or material concerns that may impact terms: _____

Agency Name _____ Agent/Broker _____
Agency Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____
E-mail (required) _____ Web site _____

Please send completed form to DandO@5starSP.com or Fax 866.720.5003