



Restaurant Program Insurance Application

Please Return Application to:

FAX: (877) 644-3670

General Information				
Franchisee/Owner Name:		Company Name:		Years in Business:
Insurance Contact Name:		Email Address:		
Phone Number:		Fax:		
Tax I.D.#:		Mobile:		
Mailing Address:				
City:	State:	ZIP Code:		
Policy Expiration Dates				
Property/General Liability Renewal Date (MM/DD/YY):				
Worker's Compensation Renewal Date (MM/DD/YY):				
Employment Practices Liability Renewal Date (MM/DD/YY):				
Ownership Information				
Name	Title	Ownership %	Include / Exclude From Work Comp	Est. Annual Payroll
Workers Compensation – Payroll Information				
Payroll Class	State (FL, MS, GA, etc..) Please separate by state	# of Part-Time	# of Full-Time	Est. Annual Payroll
Restaurant				
Supervisor, etc.				
Clerical Office & Administration				
NCCI Experience MOD Factor:				

NOTE: 5 Year loss runs required

FAX Completed Application to: (877) 644-3670

Besnard Insurance
 Questions? (877) 200-1718 or
Todd.Cicero@BesnardInsurance.com
www.BesnardInsurance.com
 CA License 0G76719

Property Information – By Store Location			
Store Number:	Building Value (if owned):	Est. Contents Value:	Est. Store Sales:
Est Year Built:	Est. Square foot area of store:	Construction Type**:	
** Construction Type: Frame/Wood (F), Joisted Masonry (JM), Non-Combustible (NC), Masonry Non-Combustible (MNC), Modified Fire Resistive (MFR), Fire Resistive (walls are steel or concrete)(FR)			
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COVERAGES TO CONSIDER

Employment Practice Liability Insurance (EPLI)			
Do you currently carry Employment Practice Liability Insurance? (Yes / No)		If YES, current "Prior and Pending" Date:	
Have any EPL Claims been made in the last 5 years?		If YES, explain	
Policy Limits (Choose one):	\$500,000 / \$500,000	\$1,000,000 / \$1,000,000	
Wage & Hour Sub-Limit (Choose one):	\$150,000 defense only	\$50,000 defense only	Exclude Wage & Hour
Trade Name Restoration (Food Borne Illness)			
Receive additional information / quote (Yes or No):	YES	NO	
Network Security / Cyber Liability			
Receive additional information / quote (Yes or No):	YES	NO	

Authorized Person's Name:	
Authorized Signature:	Date:

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