

"OPEN" CARGO APPLICATION

INSTRUCTIONS

Please complete this application. **Leave NO blanks.** Place something in each field, either a "zero" or "N/A."

Fax the completed Application to: +1.419.715.4723.

CONTACT INFORMATION				
Name of Assured:				
Contact Person:				
Address of Assured:				
City:				
State/Province:		Country:		Zip/Post Code
Telephone:		Fax:		
Email:				
Year of Formation:		<input type="checkbox"/> Privately Owned	<input type="checkbox"/> Publicly Owned	<input type="checkbox"/> State Owned
Business of Insured	<input type="checkbox"/> Manufacturer <input type="checkbox"/> Retailer <input type="checkbox"/> Wholesaler <input type="checkbox"/> Distributor <input type="checkbox"/> Forwarder			
Type of Packing	<input type="checkbox"/> Wooden Cases	<input type="checkbox"/> Cartons	<input type="checkbox"/> Bales	<input type="checkbox"/> Drums
	<input type="checkbox"/> Bulk	<input type="checkbox"/> Palletized	<input type="checkbox"/> Shrink-Wrapped	<input type="checkbox"/> Bags (Type & Ply) _____
Container Service:	_____ % Contemplated			
Method of Container Service (check)	<input type="checkbox"/> Door-to-Door <input type="checkbox"/> Pier-to-Door <input type="checkbox"/> Pier-to-Pier			
Terms of Coverage	<input type="checkbox"/> All Risks			
	<input type="checkbox"/> Other (specify) _____			
Desired Deductible Amount	\$ _____	Percentage TSI:		
Current Deductible If Different From Above	\$ _____			
Geographic Scope	<input type="checkbox"/> Import <input type="checkbox"/> Export <input type="checkbox"/> World-to-World <input type="checkbox"/> Other (specify) _____			
Principle Trading Areas				
From	Via (Port)	To	Terms of Sale	Est Annual Volume (Indicate % Insured)
Basis of Valuation:	Cost Plus Freight Plus _____ %		Other: _____	
Avg Value Per Shipment:	\$ _____	Max Value Per Shipment:	\$ _____	
Limits of Liability Required:	Any One Vessel: \$ _____		Any One Aircraft: \$ _____	
	Foreign Post/FedEX (Per Pkg) \$ _____		Any One Barge/Tow \$ _____	
Est. Annual Volume of Shipments:			Annual Gross Sales:	\$ _____
Current Insurance Carrier: _____				
Has Current Carrier Requested Replacement of Coverage or Given Notice of Cancellation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If NO Cargo Insurance is now in force, how has your insurance been handled until now?				
<input type="checkbox"/> A)- Insured through Freight Forwarder				
<input type="checkbox"/> B)- Insured by Customer or Supplier				
<input type="checkbox"/> C)- Other – If Other, Explain: _____				

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Marine Premium & Loss Experience Last Five (5) Years						
Year	Premium	Paid Losses	Outstanding Losses	Recoveries	Principle Cause of Loss	# of Claims

Does the Above Premium Include Any Warehouse Premium? Yes No

Additional Coverages To Be Included In Quotation:	<input type="checkbox"/> War, Strikes Riots & Civil Commotions	<input type="checkbox"/> Duty	<input type="checkbox"/> Contingent Interest	<input type="checkbox"/> FOB/FAS
	<input type="checkbox"/> Increased Value / DIC	<input type="checkbox"/> Domestic Inland Transit	<input type="checkbox"/> Domestic / Foreign Warehouse Coverage	<input type="checkbox"/> Domestic / Foreign Processors
	<input type="checkbox"/> Other (specify)			

Description of Domestic Inland Transit Operations (If Coverage Requested)

Geographic Limitations:			
Avg Value Per Shipment:	\$	Max Value Per Shipment:	\$
Limits Required:	\$	Est. Annual Volume:	
Valuation:			
Modes of Transit:	Rail:	%	Common Carrier:
	Owned Truck:	%	Air:
Shipment Security (Seals, Locks, Alarms, etc.)			
Inland Transit Losses:			

Description of Domestic/Foreign Warehouse/Processing Operations (If Coverage Requested)

Location (Name & Address)	Avg Monthly Value	Max Value	Limit
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
Unnamed Location Coverage Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Requested Limit:	\$
Are Any of These Locations Owned and/or Operated by Applicant?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Anticipated Attachment Date:

Any other relevant information:

I confirm that this form has been completed accurately and that all material information has been given. Completion of this form is not binding on either party.

The applicant(s) declares and warrants that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell, nor the applicant to purchase, this insurance. Any insurance contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy. A signed application dated not more than 45 days prior to the inception date will be required in the event coverage is effected.

Applicant's Signature:

Title:

Date:

Producer: Mike Miller – Managing Director – Allcovered, Inc.

Adresse: PO Box 1439 / 304 MLK Jr Dr / Fort Valley, GA 31030 USA

Producer Code: