



# BOP Application

**SPECIAL NOTE: Dryden's BOP program has limited eligibility. Please contact an underwriter to verify risk acceptability prior to completing application. This application is not acceptable for our other programs.**

Applicant's Name, Address, City, State & Zip

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant Phone: \_\_\_\_\_

Inspection Name/Local Caretaker: \_\_\_\_\_

Inspection Phone: \_\_\_\_\_

Personal Name (if different) and all owners names: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Agent Name

\_\_\_\_\_  
\_\_\_\_\_

Agent Code: \_\_\_\_\_

\_\_\_\_ Quote Only

\_\_\_\_ Bound App Eff: \_\_\_\_\_ to \_\_\_\_\_

Policy Type: Business Owners Package

## PROPERTY COVERAGE

Location Address: \_\_\_\_\_ Loc: \_\_\_\_\_ Bldg: \_\_\_\_\_

Protection:  Highly Protected  Protected  Semi-Protected  Unprotected

Feet From Hydrant: \_\_\_\_\_ Miles from Fire Dept: \_\_\_\_\_ Fire District: \_\_\_\_\_

Construction:  Masonry  Frame  Fire Resistive (Metal buildings will be rated as frame)

Year of Construction: \_\_\_\_\_ Total Square Feet: \_\_\_\_\_

Occupancy/Desc of Risk: \_\_\_\_\_

Building Coverage Limit: \$ \_\_\_\_\_ **(If building coverage, photo required)**

Deductible:  \$250  \$500  \$1,000  \$2,500  \$5,000  \$10,000

Valuation:  Replacement Cost (SF-27A)  Actual Cash Value

Form:  SF-1 – Basic  SF-2 – Broad  SF-3 – Special

Contents Coverage Limit: \$ \_\_\_\_\_

Deductible:  \$250  \$500  \$1,000  \$2,500  \$5,000  \$10,000

Valuation:  Replacement Cost (SF-27A)  Actual Cash Value

Form:  SF-1 – Basic  SF-2 – Broad  SF-4 – Special

Utility Updates (Please indicate year updated): \_\_\_\_\_ Roof \_\_\_\_\_ Electrical \_\_\_\_\_ Heating \_\_\_\_\_ Plumbing

Type of wiring:  Circuit Breakers  Fuses # of Amps? \_\_\_\_\_

Type of Furnace: \_\_\_\_\_ Type of Fuel: \_\_\_\_\_

Mortgagee Name: \_\_\_\_\_ Loan #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

**For Additional Buildings/Locations attach a Separate Application.**

**BUSINESSOWNERS PROPERTY SF-311**

Type:  Service  Mercantile  Apartment  Office  Church

Plan:  Standard  Deluxe

Occupancy:  Owner  Tenant – Lessor Sole Occupancy (Y/N)? \_\_\_\_\_

**Optional Coverages**

Accounts Receivable \$ \_\_\_\_\_ (\$1,000 included in deluxe plan)

Additional Expense \$ \_\_\_\_\_ (\$1,000 included in deluxe plan)

Employee Dishonesty # of employees: \_\_\_\_\_ \$ \_\_\_\_\_ (\$1,000 included in deluxe plan)

Exterior Signs \$ \_\_\_\_\_ (\$1,000 included in deluxe plan)

Loss of Income # of additional months: \_\_\_\_\_ (3 months incl in standard plan/6 months incl in deluxe plan)

Money & Securities \$ \_\_\_\_\_ (\$1,000 included in deluxe plan)

Outside Grade Floor Building Glass (SF-78) \_\_\_\_\_ linear feet

Seasonal Variation Designated 90 day period from: \_\_\_\_\_ to \_\_\_\_\_

Additional 30 day period from: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ % of additional coverage above 25%

Valuable Papers & Records \$ \_\_\_\_\_ (amount of additional coverage above \$1,000)

SF-53 - Protective Safeguard Endorsement (Check all that apply)

Local Fire Alarm

Central Fire Alarm

Local Burglar Alarm

Central Burglar Alarm

Sprinkler System: \_\_\_\_\_ % of Building

**Must attach a copy of current alarm certificate/sprinkler inspection upon binding for credit to be applied**

BOP Extender Endorsements: (Choose One)

SF-513 - \$50

SF-514 - \$90

SF-515 - \$125

SF-127 Loss Payee

Name: \_\_\_\_\_ Interest: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Misc Endorsement(S) Form #: \_\_\_\_\_ Coverage \$ \_\_\_\_\_

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**INLAND MARINE**

MR-61A – Computer Coverage (\$4.50/\$1,000) \$ \_\_\_\_\_

(please attach schedule for items valued over \$1,000)

Form: \_\_\_\_\_ Desc: \_\_\_\_\_ Ded: \_\_\_\_\_ Coverage: \_\_\_\_\_

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**BOP LIABILITY COVERAGES AND OPTIONAL ENDORSEMENTS**

Coverage L – Bodily Injury & Property Damage

- \$ 100,000 Each Occurance / \$ 300,000 Aggregate
- \$ 300,000 Each Occurance / \$ 1,000,000 Aggregate
- \$ 500,000 Each Occurance / \$ 1,000,000 Aggregate
- \$ 1,000,000 Each Occurance / \$ 2,000,000 Aggregate

Coverage M – Premises Medical Payments

- \$ 1,000 Each Person / \$ 25,000 Each Accident
- \$ 1,000 Each Person / \$ 50,000 Each Accident

Form of Coverage:  OL&T (LS-1)  CGL (LS-5)  BF-CGL (LS-6)

Classification: \_\_\_\_\_ Code: \_\_\_\_\_ \$/Area: \_\_\_\_\_

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LS-44 Barber Shop & Beauty Shop: # of Beauty Shop Employees FT:\_\_\_\_ PT:\_\_\_\_ Manicurists:\_\_\_\_ Barbers:\_\_\_\_

DMIC LS-98 - Tanning Professional Liability (may apply) # of Beds: \_\_\_\_\_

- LS-50 – Employee Non-Owned Auto
- LS-50A Hired & Non-Owned Auto

LS-48 Fire Damage Legal \$ \_\_\_\_\_ (\$50,000 included in LS-6)

LS-59 Lead Exclusion (*automatically applied to ALL habitational risks*)

LS-76B Skin Care Exclusion (automatically applied to all beautician & tanning operations)

LS-70 Business Premises Exclusion other than Designated Premises (may apply to some risks)

ADDITIONAL INSUREDS (Name & Address)

1. \_\_\_\_\_ 2. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Interest: \_\_\_\_\_ Interest: \_\_\_\_\_

**UNDERWRITING INFORMATION - REQUIRED TO PROCESS APPLICATION**

A. Previous Carrier: \_\_\_\_\_

**\*\*ATTACH LOSS RUNS\*\***

B. If none, why? \_\_\_\_\_

C. Has any company cancelled, non-renewed or refused insurance (including non-payment) for this applicant (Y/N)? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

D. Any losses in the past 3 years (Y/N)? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

E. Years in business? \_\_\_\_\_

Agency Use: Attachments to Application

- Photos #: \_\_\_\_\_
- Beauty Shop Questionnaire
- Tanning Bed Supplemental Questionnaire

**REMARKS**

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For questions regarding this application, please contact Agency Service Representative:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Email Address: \_\_\_\_\_

**FAIR CREDIT REPORTING ACT NOTICE**

A Consumer Report may be requested by the insurer to which the application is assigned. Subsequent consumer reports may be requested in connection with an update or renewal or extension of the insurance for which this application is made. The applicant, upon request, will be informed whether or not a consumer report was requested and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. The undersigned hereby applies for Insurance Coverage as set forth in the application and the various attached underwriting schedules and affirms that the statements and representations made herein are to the best of his or her knowledge true.

**INSURANCE FRAUD WARNING NOTICE**

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.

Agent: \_\_\_\_\_ Date: \_\_\_\_\_ Applicant: \_\_\_\_\_

**FOR OFFICE USE ONLY**

- RATING SYSTEM CHECK: NAME/LOCATION/REFUSED
- IMAGERIGHT SEARCH
- WEB SEARCH
- INSPECT
- WAIVE INSPECTION

**Rating Information**

- Standard  Deluxe
- Year:  Prior  Since Territory:  Upstate & Suburban  Upstate Cities
- Construction:  F  M Protection:  HP \_\_\_\_\_  PR  SP  UP
- Loss Settlement - Building:  RC  ACV Rate: \_\_\_\_\_ Contents:  RC  ACV Rate: \_\_\_\_\_
- Classification:  Office  Apt  Church  Service \_\_\_\_\_  Merc. \_\_\_\_\_
- Liability Form:  LS-1  LS-5  LS-6  Premium: \_\_\_\_\_

Underwriting Approval: \_\_\_\_\_



# Dryden Mutual Insurance Company

P.O. Box 635  
Dryden, New York 13053-0635  
607-844-8106 • 800-724-0560  
607-844-4085 (fax)

## Credit Card Authorization Form

Please complete **ALL** of the following information for any new business application.

Visa  MasterCard  *These are the only cards accepted.*

Credit Card #

Expiration Date     mm/yy Amount: \_\_\_\_\_

### Billing Information as listed on the Credit Card

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Authorization Signature: \_\_\_\_\_ Date: \_\_\_\_\_

New Business

Existing Policy

Policy #: \_\_\_\_\_

Named Insured: \_\_\_\_\_

Agency Name: \_\_\_\_\_

