
P.O. Box 2575
Jacksonville, FL 32203

800-874-8053

**AGENCY/BROKER PROFILE**

Please type your answers. Use a separate sheet, if necessary. Thank you for your interest in Carolina Casualty.

1. **GENERAL INFORMATION**

|  |  |
| --- | --- |
| **1.** NAME OF FIRM:  |       |
|  |  |
| **2.** PRINCIPAL ADDRESS: |       |       |       |       |
|  | (STREET) | (CITY) | (STATE) | (ZIP) |
|  |  |
| **3.** MAILING ADDRESS: |       |       |       |       |
|  | (STREET) | (CITY) | (STATE) | (ZIP) |
|  |  |
|  |
| **4.** PHONE:       | FAX:       | 800:      | WEBSITE ADDRESS:       |
|  |  |
| **5.** TYPE OF ENTITY: [ ]  CORPORATION [ ]  PARTNERSHIP [ ]  INDIVIDUAL **FEDERAL ID #**       |
|  |
| **6.** PLEASE LIST/ATTACH ALL BRANCH LOCATIONS & STATES, if any:       |

1. **BACKGROUND**

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| **1.** YEAR BUSINESS ESTABLISHED: |       |
|  |  |
| **2.** DURING THE PAST FIVE YEARS HAS THE FIRM ACQUIRED/MERGED WITH ANOTHER FIRM OR HAS THE FIRM CHANGED NAMES? | [ ]  YES [ ]  NO |
| IF YES, PLEASE DESCRIBE:       |
|  |  |
| **3.** IS FIRM ENGAGED IN, OWNED BY, ASSOCIATED OR AFFILIATED WITH, OR CONTROLLED BY ANY OTHER BUSINESS INTEREST?  | [ ]  YES [ ]  NO |
| IF YES, PLEASE EXPLAIN:      |
|  |  |
| **4.** ARE YOU A MEMBER OF: [ ]  ATA [ ]  TCA [ ]  NAPSLOC [ ]  AAMGA [ ]  OTHERS  |
| IF OTHERS, PLEASE LIST:       |

1. **PRINCIPALS AND PERSONNEL**

|  |  |  |  |
| --- | --- | --- | --- |
| **BREAKDOWN OF PRODUCER’S STAFF (Number):** | **Current Year** |  | **Prior Year** |
|  PRINCIPALS, PARTNERS, OWNERS: |       |  |       |
|  OFFICERS, MANAGERS: |       |  |       |
|  BROKERS (Other than above):  |       |  |       |
|  UNDERWRITERS: |       |  |       |
|  OTHER EMPLOYEES: |       |  |       |
|  TOTAL STAFF: |       |  |       |

1. PRINCIPALS, OFFICERS, BROKERS – LIST IN ORDER OF PERCENTAGE OF OWNERSHIP:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** |  | **TITLE OR POSITION** |  | **YEAR STARTED IN INSURANCE** |  | **YEAR STARTED WITH PRODUCER** |  | **PERCENT OWNERSHIP** |
|       |  |       |  |  |  |       |  |       |
|       |  |       |  |  |  |       |  |       |
|       |  |       |  |  |  |       |  |       |
|       |  |       |  |  |  |       |  |       |
|       |  |       |  |  |  |       |  |       |

1. **OPERATIONS**

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| 1. DOES YOUR FIRM OPERATE AS A WHOLESALER, MGA, RETAILER OR COMBINATION?
 |
|     % RETAIL |     % WHOLESALE BROKERAGE |     % MGA BINDING AUTHORITY |
|  |  |
| 1. HOW IS YOUR ORGAINZATION LICENSED, I.E., EXCESS AND SURPLUS LINES BROKER, REINSURANCE INTERMEDIARY, OR OTHER INSURANCE/REINSURANCE ORGANIZATION?

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| 1. PLEASE LIST THE STATES WHERE YOU WILL WRITE TRUCKING BUSINESS WITH CAROLINA CASUALTY AND ARE LICENSED IN THAT STATE:

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|  |  |
| 1. IF YOU ARE AN MGA, DO THE RETAIL AGENTS/BROKERS FOR WHOM YOU PLACE BUSINESS

SIGN A CONTRACT REGARDING SUBMISSION OF BUSINESS AND PAYMENT OF PREMIUM?  [ ]  YES [ ]  NO  IF YES, PLEASE ATTACH A COPY OF THE AGREEMENT. |
|  |  |

1. **PREMIUM VOLUME & DISTRIBUTION**
2. YOUR TOTAL VOLUME OF BUSINESS:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COMMERCIAL AUTO (Liability)** | PRIOR YEAR |  | CURRENT YEAR |  | NEXT YEAR |
|  Large Fleet Truck (50 to 250 power units) |       |  |       |  |       |
|  X-Large Fleet Truck (250+ power units) |       |  |       |  |       |
|  Business Auto |       |  |       |  |       |
| Other: |       |  |       |  |       |  |       |

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| --- | --- | --- | --- | --- | --- |
| **COMMERCIAL AUTO (Physical Damage)**  | PRIOR YEAR |  | CURRENT YEAR |  | NEXT YEAR |
| Large Fleet Truck (50 to 250 power units) |       |  |       |  |       |
| X-Large Fleet Truck (250+ power units) |       |  |       |  |       |
| Business Auto |       |  |       |  |       |
| Other: |       |  |       |  |       |  |       |
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|  | PRIOR YEAR |  | CURRENT YEAR |  | NEXT YEAR |
| **CARGO** |       |  |       |  |       |
|  |  |  |  |  |  |
| **GENERAL LIABILITY**  |       |  |       |  |       |
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| **EXCESS & UMBRELLA** |       |  |       |  |       |
|  |  |  |  |  |  |
| **WORK COMP & OCC ACC** |       |  |       |  |       |
|  |  |  |  |  |  |
| **PROPERTY** |       |  |       |  |       |
|  |  |  |  |  |  |
| **O/O NTAL / PHYSICAL DAMAGE** |       |  |       |  |       |
|  |  |  |  |  |  |
| Other, please describe:  |       |
|  |  |  |  |  |  |

1. LIST YOUR MAJOR INSURANCE COMPANIES IN ORDER OF PREMIUM VOLUME:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** |  | **YEARSREPRESENTED** |  | **ANNUAL VOLUME** |  | **LOSSRATIO** |  | **BINDING AUTHORITY (YES / NO)** |  | **NUMBER OF YEARS** |
|       |  |       |  |       |  |       |  |       |  |       |
|  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |  |       |  |       |  |       |  |       |
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|       |  |       |  |       |  |       |  |       |  |       |
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| 1. DESCRIBE THE SCOPE OF BINDING AUTHORITY, I.E., LIMIT OF AUTHORITY, LINES, ETC.:

      |
|  |
| 1. COMPANIES DISCONTINUED IN THE LAST FIVE YEARS:

      |
| 1. DO YOU ADJUST CLAIMS FOR ANY COMPANIES YOU REPRESENT?

IF YES, PLEASE EXPLAIN:       | [ ]  YES [ ]  NO  |
|  |
| 1. DESCRIBE ANY SAFETY OR LOSS CONTROL SERVICES PROVIDED BY YOUR ENTITY:

      |

1. **PRODUCTION TO COMPANY**

ANTICIPATED PREMIUM $ VOLUME TO CAROLINA CASUATLY WILL COME FROM THE FOLLOWING SOURCES:

|  |  |  |  |
| --- | --- | --- | --- |
|  | 50 to 250 TRUCK FLEETS |  | 250 & above TRUCK FLEETS |
| **1.** NEW BUSINESS |       |  |       |
| **2.** TRANSFER FROM CURRENT COMPANY |       |  |       |
| **3.** TRANSFER FROM DISCONTINUED COMPANY  |       |  |       |
| **4.** TOTAL (1+2+3) |       |  |       |
| COMMENTS:       |

1. **FINANCIAL INFORMATION**

 IF NOT HANDLED BY MAIN OFFICE, PROVIDE ADDRESS:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. ADDRESS:
 |       |       |       |       |
|  | (STREET) | (CITY) | (STATE) | (ZIP) |
|  |  |  |  |  |
|  |       |       |       |
|  | (PHONE) | (FAX) | (EMAIL ADDRESS) |
|  |  |  |  |
| 1. NAME OF ACCOUNTINGCONTACT:
 |       |
|  |  |  |  |

1. BANK REFERENCE:

|  |  |  |
| --- | --- | --- |
| NAME:       | TRUST ACCOUNT #:       | OTHER:        |
| BANK CONTACT:       | PHONE:       |

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| **4.** DO YOU MAINTAIN FIDELITY COVERAGE? ARE OFFICERS COVERED? [ ]  YES [ ]  NO  IF YES, PROVIDE THE FOLLOWING:  |
|  |  |
| INSURANCE COMPANY:  |       |
|  |  |
| POLICY LIMITS:  |       |
|  |  |
| POLICY DEDUCTIBLE:  |       |
|  |  |
| EXPIRATION DATE:  |       |

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| --- |
| **5.** DO YOU MAINTAIN E & O COVERAGE? [ ]  YES [ ]  NO IF YES, PROVIDE THE FOLLOWING: |
| INSURANCE COMPANY:  |       |
|  |  |
| POLICY LIMITS: |       |
|  |  |
| POLICY DEDUCTIBLE:  |       |
|  |  |
| EXPIRATION DATE:  |       |

|  |  |
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| **6.**  HAS ANY MEMBER OF YOUR FIRM RECEIVED ANY DISCIPLINARY ACTION BY A STATE INSURANCE DEPARTMENT OR OTHER REGULATORY AUTHORITY?  |  [ ]  YES [ ]  NO  |
| IF YES, EXPLAIN:       |

|  |  |
| --- | --- |
| **7.** IS THERE ANY PENDING OR THREATENED LITIGATION OR JUDGEMENTS WITHIN THE PAST FIVE YEARS EXCEEDING $10,000 AGAINST THE AGENCY/BROKER OR ANY OF ITS PRINCIPALS?  |  [ ]  YES [ ]  NO |
| IF YES, EXPLAIN:       |

THE UNDERSIGNED HEREBY DECLARES THAT THE ANSWERS GIVEN WITH RESPECT TO THE FOREGOING QUESTIONS ARE TRUE, COMPLETE AND ACCURATE WITH NO MISREPRESENTATIONS, OMISSIONS, OR ANY CONCEALMENT OF FACT.

|  |
| --- |
| SIGNATURE OF APPLICANT:       |
|  |  |
| TITLE OF APPLICANT:        | DATE OF SIGNATURE:      |

 ***Please return this completed profile to us via email or U.S. mail.***

Email: agentappt@carolinacas.com

Mailing address:

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P.O. Box 2575

Jacksonville, FL 32203

Attn: Wendy Rhodes

Phone: 800-874-8053