

OWNERS AND CONTRACTORS PROTECTIVE LIABILITY DECLARATIONS

INSURER:	PRODUCER:
NAMED INSURED: _____ MAILING ADDRESS: _____ _____	
POLICY PERIOD: FROM _____ TO _____ AT 12:01 A.M. TIME AT YOUR MAILING ADDRESS SHOWN ABOVE LOCATION OF COVERED OPERATIONS: _____ _____	
DESIGNATED CONTRACTOR: _____ _____	
MAILING ADDRESS: _____ _____ _____	

IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.

LIMITS OF INSURANCE	
EACH OCCURRENCE LIMIT	\$ _____
AGGREGATE LIMIT	\$ _____

DESCRIPTION OF BUSINESS	
FORM OF BUSINESS:	
<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> PARTNERSHIP
<input type="checkbox"/> LIMITED LIABILITY COMPANY	<input type="checkbox"/> JOINT VENTURE
<input type="checkbox"/> ORGANIZATION, INCLUDING A CORPORATION (BUT NOT INCLUDING A PARTNERSHIP, JOINT VENTURE OR LIMITED LIABILITY COMPANY)	

CLASSIFICATION AND PREMIUM				
CLASSIFICATION	CODE NO.	PREMIUM BASE	RATE PER 1,000 OF COST	ADVANCE PREMIUM
		\$	\$	\$
		STATE TAX OR OTHER (if applicable)	\$	_____
		TOTAL PREMIUM (SUBJECT TO AUDIT)	\$	_____
PREMIUM SHOWN IS PAYABLE:		AT INCEPTION	\$	_____
		AT EACH ANNIVERSARY	\$	_____
(IF POLICY PERIOD IS MORE THAN ONE YEAR AND PREMIUM IS PAID IN ANNUAL INSTALLMENTS)				
AUDIT PERIOD (IF APPLICABLE)	<input type="checkbox"/> ANNUALLY	<input type="checkbox"/> SEMI-ANNUALLY	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> MONTHLY

ENDORSEMENTS
ENDORSEMENTS ATTACHED TO THIS POLICY:

THESE DECLARATIONS, TOGETHER WITH THE COMMON POLICY CONDITIONS AND COVERAGE FORM(S) AND ANY ENDORSEMENT(S), COMPLETE THE ABOVE NUMBERED POLICY.

Countersigned:	By:
(Date)	(Authorized Representative)

NOTE

OFFICERS' FACSIMILE SIGNATURES MAY BE INSERTED HERE, ON THE POLICY COVER OR ELSEWHERE AT THE COMPANY'S OPTION.