

POLICY NUMBER:

COMMERCIAL GENERAL LIABILITY  
CG DS 01 10 01

# COMMERCIAL GENERAL LIABILITY DECLARATIONS

<b>INSURER:</b>	<b>PRODUCER:</b>
NAMED INSURED: _____	
MAILING ADDRESS: _____	
POLICY PERIOD: FROM _____ TO _____ AT 12:01 A.M. TIME AT YOUR MAILING ADDRESS SHOWN ABOVE	

**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.**

<b>LIMITS OF INSURANCE</b>		
EACH OCCURRENCE LIMIT	\$ _____	
DAMAGE TO PREMISES		
RENTED TO YOU LIMIT	\$ _____	Any one premises
MEDICAL EXPENSE LIMIT	\$ _____	Any one person
PERSONAL & ADVERTISING INJURY LIMIT	\$ _____	Any one person or organization
GENERAL AGGREGATE LIMIT	\$ _____	
PRODUCTS/COMPLETED OPERATIONS AGGREGATE LIMIT	\$ _____	

<b>RETROACTIVE DATE (CG 00 02 ONLY)</b>
THIS INSURANCE DOES NOT APPLY TO "BODILY INJURY", "PROPERTY DAMAGE" OR "PERSONAL AND ADVERTISING INJURY" WHICH OCCURS BEFORE THE RETROACTIVE DATE, IF ANY, SHOWN BELOW.
RETROACTIVE DATE: _____
(ENTER DATE OR "NONE" IF NO RETROACTIVE DATE APPLIES)

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



ALL PREMISES YOU OWN, RENT OR OCCUPY (use following page if more than 5 locations/codes)	
LOCATION NUMBER	ADDRESS OF ALL PREMISES YOU OWN, RENT OR OCCUPY

CLASSIFICATION AND PREMIUM							
LOCATION NUMBER	CLASSIFICATION	CODE NO.	PREMIUM BASE & AMOUNT	RATE		ADVANCE PREMIUM	
				Prem/Ops	Prod/Comp Ops	Prem/Ops	Prod/Comp Ops
			\$	\$	\$	\$	\$
			\$	\$	\$	\$	\$
			\$	\$	\$	\$	\$
			\$	\$	\$	\$	\$
			\$	\$	\$	\$	\$
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.



