

Send this completed form to NCMIC Insurance Services:

FAX: 866-852-8522 EMAIL: agents@ncmic.com MAIL: PO Box 9118 Des Moines, IA 50306-9118
 OR CALL: 800-394-1466

Individual Name _____

Practice Name _____

Mailing address _____

City _____ State _____ Zip Code _____

Practice address is same as mailing address. If not, complete the information below.

Practice Address _____

City _____ State _____ Zip Code _____

Business type Individual Corporation LLC Other _____

Telephone _____ Fax _____

Email _____

Your e-mail address will never be sold. It will be used to send you important notices.

Gross annual receipts _____ Percent revenue from Supplement sales _____%

Do you have Business Owners' Coverage now? Yes No Do you offer Yoga Classes at your office? Yes No

Current carrier _____ Renewal date _____

No. of years in business _____ No. of years in business at this location _____

No. of full-time employees _____ No. of part-time employees _____

Building construction Frame Brick Concrete Other

Year building was built _____ No. of stories: _____ Sprinklers Yes No

Are you the owner of the building? Yes No If yes, value of building \$ _____ and year of last updates to:
 roof _____, electrical _____, plumbing _____, heating _____

Square feet of your business _____ Full square feet of building (if owned) _____

Value of contents (computers, furniture, tables, desks, artwork, etc.) \$ _____

Any Claims past 5 years? Yes No Reason: _____ Amount Paid \$ _____

Choose a deductible \$500 \$1,000 Other \$ _____

Choose a liability coverage amount \$1 million per occurrence/\$2 million aggregate

\$2 million per occurrence/\$4 million aggregate

Workers' Comp Insurance

Total No. of employees _____ Owners/Officers included? Yes No

Total annual payroll \$ _____ Employer Federal Tax ID _____

Any WC Claims past 5 years? Yes No Reason: _____ Amount Paid \$ _____

Please contact me about Auto Insurance Homeowners Insurance Umbrella Insurance