

Beckman Insurance Agency

2878 S. 171st St.

New Berlin, WI 53151

(800)345-2881

Fax: (262)797-9048

SKI AREA LIABILITY APPLICATION

Name of applicant and Ski Area: _____

Location: _____ County: _____

Mailing Address: _____

Individual Partnership Corporation Joint Venture Other*

*If other, please describe _____

Policy Period Requested _____ to _____

of Years in Business: _____

Period of Operation: Year Round Yes No Seasonal Yes No From _____ to _____

Hours of Operation: Daytime---From _____ to _____

Evening---From _____ to _____

Office Hours: From _____ to _____

Contact Person: Business Manager _____ Telephone _____

Engineering _____ Telephone _____

Accounting _____ Telephone _____

Number of Ski Runs: _____ Vertical Drop 1: _____ Vertical Drop 2: _____

(Please Attach Brochure and Copy of Expiring Policy)

SCHEDULE OF OPERATIONS

Ski Lifts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ski School	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ski Equipment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Snow Boarding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bar	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Restaurant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hotel/Motel Lodging	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nursery/Day Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ski Shop Sales	<input type="checkbox"/> Yes	<input type="checkbox"/> No

	Expiring Year	Prior Year
Gross Sales	_____	_____
Gross Sales	_____	_____
Gross Sales	_____	_____
Gross Sales	_____	_____
Gross Sales	_____	_____
Gross Sales	_____	_____
Gross Sales	_____	_____
Gross Sales	_____	_____
Gross Sales	_____	_____

Other Receipts Not Included Above. Please Describe

Gross Sales	_____
_____	_____
_____	_____
_____	_____

Please Describe Any Summertime Activities

Gross Sales	_____
_____	_____
_____	_____

ADDITIONAL INFORMATION

Prior Year Skier Days (If Available) _____

Ski Lifts: (number of each)

Chair Lifts _____	2 Seat _____	4 Seat _____	T Bar _____
Rope Tows _____	Cable Tows _____	Gondolas _____	& Capacity _____
Other (List) _____		Number _____	

ADDITIONAL INTEREST/CERTIFICATE RECIPIENTS

Name & Address	Interest	Certificate
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRIOR CARRIER & LOSS INFORMATION: (Please provide a loss statement from your present carrier for the last 3 years. If new operation for period of time in business, also include premium paid for same period).

Year From	To	# of Losses	Total Paid Losses	Carrier	Premium	Limit	Deductible

For each claim in excess of \$10,000 describe: (attach sheet with further details if necessary)

Do you require signed releases for the following?

1. Ski Clubs Yes No

2. Season Ticket Holders Yes No

3. Other _____ Yes No

(Please attach copy of release presently being used)

Are Sub-Contractors Hired? Yes No

(If yes, attach copy of certificate of insurance)

If Alcoholic Beverages served, please complete the Liquor Liability Supplemental.

Is Liquor allowed out of building? Yes No

If this is a renewal, please list any changes of Operation!! EXAMPLE: New Building, Additional Ski Runs, Other Operations.

The Following Documents should be attached to this document where applicable:

Hold Harmless Agreements Yes No

Rental Agreements Yes No

Certificate of Insurance Yes No

The following employee information is required:

Number of full time employees (over 20 hrs / week) _____

Number of part time employees _____

Prior year gross payroll _____

LIMITS OF LIABILITY

All limits are subject to Company acceptance and approval. There is a combined single limit (CSL) for Bodily Injury and Property Damage. Please check coverage limit desired:

\$300,000 \$500,000 \$1,000,000

Occurrence Form Yes No Claims Made Form Yes No

DEDUCTIBLE: Bodily Injury Liability and Property \$ _____ per claim

Damage Liability Combined \$ _____ per occurrence

EXCESS COVERAGE

\$1,000,000 \$2,000,000 Other \$ _____

NOTE: Excess coverage will not be quoted unless \$1,000,000 CSL is the selected primary coverage.

I hereby certify that the information provided herein is true and correct. I understand that the application and supplement will become a part of the policy and any misrepresentation of the facts herein may cause the policy to be cancelled or coverage to be denied.

Signature of Applicant

Date Signed

Signature of Agent

Date Signed