pro health
PARTNERS
A Medical Group, Inc.

NEW LOCATION QUESTIONNAIRE

Name of Lessee on lease agreement:

Effective Date (date to be added):

Full Address:

Building Construction Type:

Year Building Built:

Number of Stories of Building:

Square Footage: Total Building: Area Leased:

Use of Premises:

Burglar / Fire Alarm: ☐ Yes ☐ No

If yes: Central Station Alarm? ☐ Yes ☐ No

Is there an automatic fire sprinkler system? ☐ Yes ☐ No

Building, Replacement Cost Value (if you are responsible): $

Business Personal Property Replacement Cost value:
(furniture, fixtures, including tenant improvements & betterments) $

Computer Hardware / Software Cost: $

Business Interruption / Extra Expense: $

Loss of Rents (if applicable): $

If you are NOT the sole occupant of this building, please list the types of other tenants
(i.e. offices, retail, restaurant, industrial, manufacturing, etc.)

Landlord / Property Manager Name and Address: (If leased premises)

Contact Name: Phone: Email:

Has the landlord requested to be named as an additional insured on your general liability coverage?

Yes ☐ No ☐

Please provide us with a copy of the insurance requirements section of your lease for review.

OTHER COVERAGES

For Workers Compensation, how much payroll is at this location (if any)?