ACORD®

WISCONSIN SUPPLEMENTARY LIMITED OTHER STATES COVERAGE REQUEST

DATE (MM/DD/YYYY)

AGENCY	APPLICANT
CODE: SUB CODE:	

1. Name of Insured: _____

2. Address of Insured: _____

_____

3. Legal Status: ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other: _____

4. Do you (the applicant) have any permanent business locations outside the State of Wisconsin? ☐ Yes ☐ No If "Yes", please explain.

5. Are all of your (the applicant's) employees residents of the State of Wisconsin? ☐ Yes ☐ No If "No", please list the employee's name(s) and address(es) showing the state(s) of residency.

6. Do any employees, at any time, work outside the State of Wisconsin? ☐ Yes ☐ No If yes, list states and give the type of work performed and express the amount of time spent outside of Wisconsin as a percentage (%) of the total time worked.

By my signature below, I hereby certify that I have answered all questions in this Questionnaire accurately and completely. I understand that the insurance carrier will rely upon this information in determining my/our eligibility for "Other States" coverage, and that immediate notice must be provided to the insurance carrier should any operations change in the future.

Name (Please Print): _____

Title*: _____

Signature: _____ Date: _____

* IF APPLICANT IS A CORPORATION, THIS FORM MUST BE SIGNED BY AN EXECUTIVE OFFICER. IF APPLICANT IS AN INDIVIDUAL PROPRIETOR OR PARTNER, THIS SHOULD BE SHOWN AS THE "TITLE" OF THE SIGNATORY.