CBA INSURANCES LIMITED

Please fax to: (07) 927 7721
or post to: P O Box 13-405, Tauranga

Request for Quote

YOUR DETAILS

Name: _____

(Company / Trading / Personal) _____

Postal Address: _____

_____

Contact Phone Number: _____

Contact Fax Number: _____

Email: _____

Date of Birth: Name: _____ DOB: _____

Name: _____ DOB: _____

PLANT, TOOLS & EQUIPMENT

COVERING Accidental physical loss or damage to tools, plant and equipment

CLAIM EXAMPLES - a fire destroys the building and its contents, burglary of tools from the site.

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Replacement Value of Equipment: $ _____

LIABILITIES - PUBLIC / STATUTORY/EMPLOYERS/E&O (Professional Indemnity)

COVERING Liability to other people for accidents happening in connection with your occupation

CLAIM EXAMPLES - an employee puts his foot through the ceiling, accidentally burns down house next door

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Limit of Indemnity Required: _____

Estimated Turnover: $ _____

Number of Employees: _____

How long have you been in business: _____ year/s

ANNUAL CONTRACT WORKS

COVERING Loss or damage to building projects in course of construction

CLAIM EXAMPLES - fire, storm, theft of materials

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Estimated Turnover: $ _____

Maximum Value any one house _____

MOTOR VEHICLES

COVERING Loss or damage to vehicles and Third Party liability

CLAIM EXAMPLES - vehicle involved in nose to tail accident at intersection, broken windscreen

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Date of Birth of Main Drivers: Name: _____ DOB: _____

Name: _____ DOB: _____

Year	Make	Model	Market Value	Business Use / Private Use
				Business / Private
				Business / Private
				Business / Private
				Business / Private
				Business / Private
				Business / Private

BUSINESS INTERRUPTION

COVERING Loss of turnover following an insured risk

CLAIM EXAMPLES - after a major fire in workshop, turnover is reduced to only 10% and business is unable to meet fixed costs such as wages, mortgage etc

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Gross Profit: $ _____

Gross Rents Receivable, Rates, Taxes and Insurances payable by Tenants $ _____

Additional Increased Cost of Working $ _____

Claim Preparation Costs: $ _____

INDEMNITY PERIOD: _____ Months

PERSONAL INSURANCES

HOUSE

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Situation of Property: _____

_____

_____

Area in square metres: _____

Age of house: _____

Required Excess: _____

Date of Birth: Name: _____ DOB: _____

Name: _____ DOB: _____

DOMESTIC CONTENTS

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Situation of Property: _____

Sum Insured: $ _____

Required Excess: _____

Do you have a burglar alarm? No / Yes

If yes, is it monitored? No / Yes

BOAT

Current Insurer: _____

Due Date of Current Policy: _____

Have you had any claims in the last 5 years? No / Yes *(if yes, please advise details)*

_____

_____

_____

Year/Make/Length : _____

Powered By: _____

Trailered: No / Yes

Total Sum Insured: $ _____

INCOME PROTECTION / LIFE / MEDICAL INSURANCES & SUPERANNUATION

(because of the complexity of these, we will need to contact you for more information and to discuss more deeply)

Name of Main Life to be Insured: _____

Date of Birth: _____

Smoker: No / Yes

Health: Excellent / Good / Indifferent

Details of Cover Required: (Please tick box)

INCOME PROTECTION	Weekly benefit if sick or hurt	☐
TERM LIFE	Life Insurance for Fixed term - say 10 years	☐
MEDICAL	Hospital and Medical costs	☐
SUPERANNUATION	Investment for retirement	☐