The Leading Provider of Captive Insurance Services

OXFORD
RISK MANAGEMENT GROUP

BUSINESS INTAKE FORM

Risk Management Consultant:

OPERATING COMPANY INFORMATION

Entity Legal Name:

Trade Name/DBA (if applicable):

Address:

City: State: Zip Code: Office Number: Website:

PRIMARY CONTACT

Full Legal Name: Salutation:

First Name   Middle Initial   Last Name

Title: Email: Mobile Number:

COMPANY BACKGROUND: Please provide a detailed description of the company including history and activities in which the company is engaged.

Industry: Number of Full Time Employees: Number of Part Time Employees:

Business Activities   Number of
and History: Years in Business:

CAPTIVE EXPERIENCE

Have you or the company ever evaluated or participated in captive insurance?

If so, please describe (types of captive (831(b), group, employee benefits, etc.), risks insured, status, overall

perception, etc.):

2019 V1

OXFORD
RISK MANAGEMENT GROUP

OWNERSHIP AND REVENUE: Please complete all information below for each entity to include in underwriting.

* Net Income should be prior to shareholder/owner salary, dividends and distributions

Full Legal Name of Operating Company	Name and Title of Shareholder/ Partner/Owner	Ownership %	Fiscal Year End (MM/DD)	Entity Type/Tax Classification	Current Year Projected Gross Revenue	Current Year Projected Net Income*	Next Year Projected Gross Revenue	Next Year Projected Net Income*

Please describe the relationship between owners listed above (family members, business partners, etc.):

OXFORD
RISK MANAGEMENT GROUP

EXISTING P&C COVERAGE: (check all that apply)

Commercial Policy Renewal Date (MM/DD):

Auto Liability   Crime   Cyber Liability   Directors & Officers

Employment Practices   Equipment Breakdown   Errors & Omissions   General Liability

Inland Marine   Medical Malpractice   Workers Comp   Umbrella

Product Recall   Professional Liability   Property   Transportation

Other:

Business Health Insurance: Fully Insured   Self-Insured   Uninsured

Do you currently or have you ever considered paying a premium to a Medical Stop Loss Program?:

ADVISOR INFORMATION: Please complete all information below for each of your current business advisors.

	Name	Company	Address	Phone Number	Email
P&C Agent(s)					
Attorney					
CPA					
Investment/ Financial Advisor					
Referring Advisor					