

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

DAVID BROWNING
Deputy Commissioner of Insurance



MAILING ADDRESS
Post Office Box 79
Jackson, Mississippi 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 359-2474

MISSISSIPPI INSURANCE DEPARTMENT

ELEVATOR SAFETY DIVISION
501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

Application for Elevator Contractor's License

Check appropriate box:

LLC ☐ Sole proprietor ☐ Partnership ☐ Domestic Corporation ☐ Other Corporation ☐

If a sole proprietor, the name, residence address, and business address of the applicant. If a partnership, the name and residence and business address of each partner. If a domestic corporation, the name, and business address of the corporation and the name and residence address of principal officer of the corporation. If a corporation other than a domestic corporation, the name, and address of a local agent who shall be authorized to accept service of process and official notices. Provide all information on additional sheets and attach to this application if necessary.

Name (if applicable) _____
Residence Address (if applicable) _____
Business Name _____
Business Address _____
Previous License Number (if applicable) _____
Principal Officer (if applicable) _____
Local Agent (if applicable) _____
Local Agent Address (if applicable) _____
Business Phone Number _____ Email _____
Federal Employer Identification Number (FEIN) _____

Elevator Contractor's License

Covers all activities of installation, alteration, service, replacement, or maintenance on all conveyances under statute HB 817 (2013 Regular Session). Must provide the following documentation with this application:

- 1.) A current Certificate of Insurance issued by an insurance company authorized to do business in the state to provide general liability coverage of at least one million dollars (\$1,000,000) for injury or death of any number of persons in any one occurrence and at least five hundred thousand dollars (\$500,000) for property damage in any one occurrence and the statutory workers' compensation insurance coverage. **Annual verification of coverage required.**

Provide a Certificate of Liability Insurance on the ACORD form. Only this form will be accepted. Have this form name as certificate holder: ELEVATOR SERVICES DIVISION, MISSISSIPPI INSURANCE DEPARTMENT, PO BOX 79, JACKSON, MS 39205-0079.

Effective Date of Coverage: _____

- 2.) A list of all Mississippi licensed mechanics in your employ at the time of application.
- 3.) Check or money order in the amount of \$300.00 payable to the Mississippi Insurance Department.

Number of years has your company been in the business of installing, maintaining or servicing elevators or related conveyances. _____

All records of criminal convictions of owner or mechanics, if none, please so state:

Signature _____ Date _____