**CoverX**

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Beaverton, Oregon 97007
Ph: 503-259-3060 Fax: 503-259-3065
Email: mail@evergreeninsmgrs.com
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**IMPORTANT – To be completed by Producer:**

Name:______________________________

Producer Is: ☐ Wholesaler ☐ Retailer

Address:______________________________

______________________________

Telephone:______________________________

Fax:______________________________

Email:______________________________

Proposed Effective Date:______________________________

If Renewal, Provide Current Policy No.:____________________

**IMPORTANT – To be completed by Producer who will handle the Surplus Lines transaction(s):**

**Resident or Non-Resident Surplus Lines Licensee Information for Applicant's State of Domicile:**

SL Licensee Agency Name:______________________________

SL License State:______________________________

SL License No.:______________________________ SL License Expiration Date:____________________

SL Licensee Name (if not an Entity License):______________________________

Affiliation with Producer (e.g., Owner, Executive Officer, Employee):______________________________

## ALARM OPERATIONS GENERAL LIABILITY APPLICATION

1. Applicant:______________________________
2. Street Address:______________________________

   Mailing Address (if different than above):______________________________

   Additional Locations (if any):

   a. ______________________________
   b. ______________________________
   c. If additional space is necessary, please provide additional worksheet.
3. Name of contact person for inspection/audit:____________________ Telephone No.:____________________
4. Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (Describe):____________________
5. Coverage:______________________________
6. Limits:____________________ Each Occurrence/Aggregate Deductible:____________________
7. Operations (use percent %): ________ Alarm ________ Safety Equipment ________ Other:____________________
8. How long has Applicant owned this business?______________________________
9. How many years experience does Applicant have in this field?______________________________
10. Is Applicant involved in any other operations? ☐ Yes ☐ No If Yes, please describe:____________________

    ______________________________

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11. Describe the duties of owner:______________________________________________________________

______________________________________________________________________________

12. Provide the names of Applicant's five largest clients and a description of your duties for them:

(1)___________________________________________________________________________
(2)___________________________________________________________________________
(3)___________________________________________________________________________
(4)___________________________________________________________________________
(5)___________________________________________________________________________

13. Signed contract with all customers? ☐ Yes ☐ No

14. Percent of customers under your standard contract:____________%

Percent of customers under modified contracts or contracts of others:____________%

***PLEASE ATTACH COPY OF YOUR STANDARD CUSTOMER CONTRACT OR PURCHASE ORDER.***

15. Pre-employment Screening Procedure (check applicable):

_____ Prior Employment Check _____ Drug Screening _____ Personal Reference _____ Psychological Testing
_____ Polygraph _____ MVR _____ Background Check _____ Other

Please describe "Other":______________________________________________________________

16. Training Program Consists of (check all applicable):

_____ Written Manual _____ Report Writing _____ CPR _____ On The Job
_____ Firearms _____ Use of Force _____ Powers of Arrest _____ Other

Please describe "Other":______________________________________________________________

17. Is the Applicant licensed? ☐ Yes ☐ No If Yes, please list all licenses:______________________________

______________________________________________________________________________

______________________________________________________________________________

18. Does Applicant perform any design work for a fee (not associated with your installation)? ☐ Yes ☐ No

If Yes, fully describe:________________________________________________________________

______________________________________________________________________________

19. Describe Trade Association Memberships held:____________________________________________

**Claim/Loss History:** If none, so state. Attach five (5) years currently valued loss runs with application, if available. Verified loss runs required to bind.

| Date | Description | Paid Amount | Reserves | Status (Open/Closed) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Describe any additional incidents that have occurred that may result in a claim being made against Applicant. If none, so state:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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**Policy Information:**

| Carrier | Policy Period (month/day/year) | Limits | Premium | Receipts or Payroll | Deductible |
|---|---|---|---|---|---|
| ______ | ______ | ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ | ______ | ______ |
| ______ | ______ | ______ | ______ | ______ | ______ |

Has any carrier cancelled or refused to renew? ☐ Yes ☐ No If Yes, please describe:______________________

______________________________________________

**ALARM COMPANY OPERATIONS – PROVIDE BREAKDOWN OF APPLICABLE OPERATIONS:**

| Client Base: | New Construction | Rehab / Retrofit Service / Repair |
|---|---|---|
| Commercial | ______% | ______% |
| Industrial | ______% | ______% |
| Institutional | ______% | ______% |
| Apartments | ______% | ______% |
| Single Family | ______% | ______% |
| Condos | ______% | ______% |
| Tract Housing | ______% | ______% |
| Custom Homes | ______% | ______% |
| Single Family, Condos, Tract Housing, or Custom Homes Work for Builder | ______% | ______% |

**GROSS RECEIPTS BREAKDOWN BY ALARM & RELATED OPERATIONS**

Receipts Breakdown:

| | Sales / Installation Service / Repair | Monitoring |
|---|---|---|
| Fire / Smoke / Heat Detection | $______ | $______ |
| Burglary (Perimeter / Internal / Motion Detector) | $______ | $______ |
| Personal Emergency / Panic Button | $______ | $______ |
| Medical Emergency Pendants | $______ | $______ |
| Medication Reminder Service | $______ | $______ |
| Carbon Monoxide Detection | $______ | $______ |
| Utility Monitors (HVAC / Water / Gas) | $______ | $______ |
| Water Flow on Sprinkler System | $______ | $______ |
| Temperature Control | $______ | $______ |
| Closed Circuit TV | $______ | |
| Central Vacuum | $______ | |
| Home Theater | $______ | |
| Intercom | $______ | |
| Preconstruction Wiring / Conduit | $______ | |
| Other | $______ | $______ |
| Other | $______ | $______ |
| **SUB-TOTAL:** | $______ | $______ |

**TOTAL:**______________

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**PAYROLL AND SUBCONTRACTOR'S COSTS**

Total Projected Annual Payroll: $________________________ (excluding Admin., Sales, Clerical)

Total Projected Subcontract Costs (other than Monitoring): $________________________ (if applicable)

Total Projected Subcontractor's Costs for Monitoring: $________________________ (if applicable)

Are any of the above part of wrap-up or OCIP projects? ☐ Yes ☐ No. If Yes, Receipts?____________________________________

______________________________________________________________________________

______________________________________________________________________________

If Applicant does not monitor alarms, names(s) of your monitoring subcontractor:______________________________________

Written contract with monitoring company? ☐ Yes ☐ No

Fully describe alarm response procedures:________________________________________________________

______________________________________________________________________________

**SAFETY EQUIPMENT OPERATIONS (Other than Alarm Operations) – PROVIDE BREAKDOWN OF APPLICABLE OPERATIONS:**

| Payroll | Receipts | | Payroll | Receipts | |
|---|---|---|---|---|---|
| __________ | __________ | Sales/Distribution | __________ | __________ | Manufacturing |
| __________ | __________ | Service | __________ | __________ | Other |
| __________ | __________ | Installation | | | |

Fully describe "Other" operations:________________________________________________________________

______________________________________________________________________________

______________% Hand Held Extinguishers ______________% Personal/Safety First Aid _____________% Other

Describe other products sold or handled by Applicant (protective clothing, life support, etc.):____________________________________

______________________________________________________________________________

Identify Manufacturers:____________________________________________________________________

Hand Held / Portable Extinguishing Equipment – Installation, Sales or Service:

___________% Factories ___________% Restaurant ___________% Computer Room

___________% Other Describe "Other":____________________________________________

Customers are: ___________% Commercial ___________% Residential ___________% New Construction

Customers: ___________ Number ___________ Under Contract $______________ Annual Contract Cost

**PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR ALARM OR SAFETY EQUIPMENT OPERATIONS:**

Do you use any subcontractors (other than for Monitoring)? ☐ Yes ☐ No

a. What kind of work is subcontracted?____________________________________________________________

   ______________________________________________________________________________

b. Do you use a written contract with all your subcontractors? ☐ Yes ☐ No If Yes, please attach a copy of the contract.

c. Do you obtain Certificates of Insurance from all your subcontractors? ☐ Yes ☐ No

d. Are you always added as an additional insured by your subcontractors? ☐ Yes ☐ No If No, give percentage:________%

e. Indicate contractually required minimum limit of liability insurance:__________________________________________

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Does Applicant install or service safety equipment in nursing homes, medical, correctional or detention facilities? ☐ Yes ☐ No

Is Applicant covered under Broad Form Vendors coverage by manufacturer? ☐ Yes ☐ No

Does the Applicant install safety equipment in buildings over four (4) stories? ☐ Yes ☐ No

Does Applicant perform any work at facilities where explosives are handled or stored or at nuclear power plants? ☐ Yes ☐ No

If Yes, describe:______________________________

______________________________

**OTHER OPERATIONS – SECURITY RESPONSE**

Does Applicant provide security/patrol response to their customers if and when local Police/Fire/EMTs do not respond? ☐ Yes ☐ No

If Yes, are the responders employees, or are they hired/contracted for this service?______________________________

______________________________

If responders are not employees, does Applicant have a written contract with the security company that provides the response?________

______________________________

If Applicant does have a contract with the security company, is either part holding the other harmless/providing indemnification?

☐ Yes ☐ No. If Yes, provide details:______________________________

______________________________

Do any employees or subcontractors carry firearms? ☐ Yes ☐ No

State Notices: The following notices are required by the Insurance Department of the indicated states.

**NOTICE TO NEW YORK APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME. (Note: This notice is required by New York insurance regulations, but may also be a crime in other states.)

**NOTICE TO TENNESSEE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO FLORIDA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

THE UNDERSIGNED DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE INSURANCE, NOR DOES REVIEW OF THE APPLICATION BIND THE INSUROR TO ISSUE A POLICY. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

SIGNED BY:

______________________________ ______________________________

Applicant Date Producer Date

(08/2005)

## NOTICE

1. **THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NONADMITTED" OR "SURPLUS LINE" INSURERS.**
2. **THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT WHICH APPLIES TO CALIFORNIA LICENSED INSURERS.**
3. **THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
4. **CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINES INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST.**
5. **FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
6. **IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY THAT YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

**Date:**______________________________

**Insured:**____________________________

**SF 198230.2 7367000741 D-1 (EFFECTIVE JANUARY 1, 2005 THROUGH DECEMBER 31, 2007)**