

CoverX



**EVERGREEN
INSURANCE
MANAGERS**

PO Box 6597
Beaverton, Oregon 97007
Ph: 503-259-3060 Fax: 503-259-3065
Email: mail@evergreeninsmgrs.com
www.evergreeninsmgrs.com

Producer: _____

Producer Is: Wholesaler Retailer

Address: _____

Telephone: _____

Fax: _____

Excess & Surplus Lines License No.: _____

Email: _____

Proposed Effective Date: _____

If Renewal, Provide Current Policy No.: _____

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

SL License State: _____

SL License No.: _____

SL License Expiration Date: _____

SL Licensee Name: _____

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

SL Licensee Agency Name (if Entity License): _____

FIRE SUPPRESSION CONTRACTORS GENERAL LIABILITY APPLICATION

1. First Named Insured: _____

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. Named Insured is: Individual Corporation Partnership Other (Describe): _____

5. COVERAGE:

LIMITS

General Aggregate _____

Products-Completed Operations Aggregate _____

Each Occurrence _____

Personal and Advertising Injury _____

Fire Damage _____

Medical Payments _____

Deductible \$ _____

6. Do your employees participate in any professional organizations such as:

NFPA SFPE NFSA AFSA Other: _____

7. How long have you owned this business? _____

8. How many years experience do you have in this field? _____

9. Are you involved in any other operations? Yes No If Yes, please describe: _____

10. Describe the duties of owner: _____

11. Provide the names of your five largest clients and a description of your duties for them:

12. Signed contract with all customers? Yes No
13. Percent % of customers under standard contract: _____

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

14. Pre-employment Screening Procedure (check applicable):
 _____ Prior Employment Check _____ Personal Reference _____ Psychological Testing _____ Other
 _____ Drug Screening _____ MVR _____ Background Check
 Please describe "Other": _____
15. 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": _____
16. Please indicate all licenses held by you and your employees: _____

17. OPERATIONS: Provide \$ Breakdown of Applicable Operations:

| Payroll | Receipts | |
|---------|----------|----------------------|
| _____ | _____ | New Installation |
| _____ | _____ | Retrofit |
| _____ | _____ | Design |
| _____ | _____ | Service/Repair |
| _____ | _____ | Inspection |
| _____ | _____ | Grease/Duct Cleaning |
| _____ | _____ | Other: _____ |

Using annual gross receipts, estimate the percentage of sales from the following categories:

| <u>OPERATIONS</u> | | <u>MARKET SEGMENTS</u> | | <u>SYSTEMS</u> | |
|-------------------|--------|------------------------|--------|------------------------|--------|
| New Installation | _____% | Commercial | _____% | Wet/Dry Sprinklers | _____% |
| Retrofit | _____% | Restaurants | _____% | Foam/Chem Systems | _____% |
| Design | _____% | Institutional | _____% | Special Hazards | _____% |
| Service/Repair | _____% | Habitational | _____% | Portable Extinguishers | _____% |
| Inspection | _____% | Residential | _____% | | |
| Grease/Duct Clean | _____% | Computer Rooms | _____% | | |
| Other: _____ | _____% | | | | |

Receipts Current Year: _____ Last Year: _____ Prior Year: _____ 2 Years Prior: _____
 Payrolls (Total) _____

18. Do you use any subcontractors? Yes No
- a. If yes, indicate annual cost: \$ _____
- b. What kind of work is subcontracted? _____

- c. Do you use a written contract with all your subcontractors? Yes No If Yes, please attach a copy of the contract.
- d. Do you obtain Certificates of Insurance from all your subcontractors? Yes No
- e. Are you always added as an additional insured by your subcontractors? Yes No If No, give percentage: _____%
- f. Indicate contractually required minimum limit of liability insurance: _____
19. Have any of your jobs been in gasoline/fueling stations, chemical plants, refineries, nuclear power plants or similar hazardous occupancies? Yes No If Yes, please indicate for whom and year done; or indicate if you intend to perform such work :____

20. Percent of jobs including:
Fire Pumps _____% Foam _____% Gas/Chemical _____% Fire Hydrants or Stand Pipes _____% Other _____%
21. If residential work is not currently done, please indicate the last year that residential work was done: _____
22. Do you install, service or repair fire suppression systems aboard aircrafts, automobiles, mobile equipment, boats? Yes No
If Yes, please describe: _____

- If No, do you anticipate performing such work in the future? Yes No
23. Do you fill any type of oxygen tanks? Yes No
24. If you perform any retrofit work, describe the type of retrofit work, occupancy, number of stories, reason for retrofit, etc.: _____

25. Do you install systems in buildings over four (4) stories? Yes No
26. Do you manufacture any fire protection equipment? Yes No
27. Do you sell any type of product including protective clothing or life support equipment? Yes No
28. Are you covered as Additional Insured under Vendors coverage by manufacturer? Yes No
29. Do you design fire suppression/extinguishing systems? Yes No
If Yes,
- a. Are employees with Level III or IV Certificates used? Yes No
- b. Is there a licensed and/or registered Professional Engineer (P.E.) on staff? Yes No
If Yes to b. above,
- (1) Does the P.E. stamp and seal their own plans? Yes No
- (2) Does the P.E. stamp and seal plans for outside firms? Yes No
- c. Are outside firms used for design work? Yes No If Yes, what percent of total design? _____%
- d. Do you do any design work for other firms? Yes No If Yes, indicate the percentage of design work done for others and describe: _____% _____
30. a. Does the plan owner or draftsman approve any changes to the specifications? Yes No
b. Does the insured management (job foreman) approve any changes to the specifications? Yes No
31. Do you prepare drawings for suppression system installations? Yes No If Yes, describe how such drawings are checked for compliance with the specifications of the system and the local building and life safety codes: _____

32. Are detailed records kept on all jobs? Yes No Please check what is typically in those records: dates
 type of work performed materials used replaced or recharged parts when the system is activated
For how long are records retained? _____
Are duplicate records kept at another location? Yes No
Do you use electronic field inspection system? Yes No

33. Who verifies at completion of the job that all work complies with NFPA Standards and local codes? _____
34. If retrofit work is done, do the job proposals and contracts include an asbestos clause mandating removal of asbestos by a third party prior to work commencement? Yes No
35. Approximately what percentage of jobs use CPVC pipe? _____% Are all of your fitters trained on the various cure times for different size pipes? Yes No
36. Describe any fuels, chemicals, or other hazardous materials stored at the job site, how they are stored/protected, and spill prevention methods: _____
- _____
- _____

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 you. If none, so state:

POLICY INFORMATION:

| Carrier | Policy Period | Limits | Premium | Exposures Basis | Deductible |
|---------|---------------|--------|---------|-----------------|------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

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

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

CONTINUED

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: _____