

# CoverX

The Coverage Experts  
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Producer: \_\_\_\_\_

Producer Is:  Wholesaler  Retailer

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

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): \_\_\_\_\_

## ALARM / SAFETY EQUIPMENT 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: \_\_\_\_\_

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 standard contract: \_\_\_\_\_

**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 work at facilities where explosives are handled or stored or at nuclear power plants?     Yes     No  
 If Yes, describe: \_\_\_\_\_
19. Does Applicant perform any design work?     Yes     No    If Yes, fully describe: \_\_\_\_\_  
 \_\_\_\_\_
20. 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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Policy Information:**

Carrier	Policy Period	Limits	Premium	Basis	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	_____ %	_____ %

**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	\$ _____	\$ _____	
<b>SUB-TOTAL:</b>	\$ _____	\$ _____	<b>TOTAL:</b> _____

**PAYROLL AND SUBCONTRACTOR'S COSTS**

Total Projected Annual Payroll: \$ \_\_\_\_\_  
 Total Projected Subcontract Costs: \$ \_\_\_\_\_  
 Total Projected Subcontractor's Costs for Monitoring: \$ \_\_\_\_\_

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

Fully describe "Other" operations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If Applicant does not monitor alarms, who does? \_\_\_\_\_

Written contract with monitoring company?  Yes  No **PLEASE ATTACH COPY OF CONTRACT WITH MONITORING COMPANY**

Fully describe alarm response procedures: \_\_\_\_\_  
 \_\_\_\_\_

**SAFETY EQUIPMENT OPERATIONS – PROVIDE BREAKDOWN OF APPLICABLE OPERATIONS:**

Payroll	Receipts		Payroll	Receipts	
_____	_____	Sales/Distribution	_____	_____	Manufacturing
_____	_____	Service	_____	_____	Other
_____	_____	Installation			

Fully describe "Other" operations: \_\_\_\_\_  
 \_\_\_\_\_

Systems are: \_\_\_\_\_% Hand Held Extinguishers \_\_\_\_\_% Personal/Safety First Aid \_\_\_\_\_% Other

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

Identify Manufacturers: \_\_\_\_\_  
 \_\_\_\_\_

Installations at: \_\_\_\_\_% 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?  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: \_\_\_\_\_

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



## 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: \_\_\_\_\_