

# CoverX

The Coverage Experts  
www.coverx.com

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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: \_\_\_\_\_