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Central Insurance Agency

93 East Main Street
Smithtown, NY 11787
TELEPHONE: (877) 242-9600
EMAIL: info@ciainsures.com

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:_____

    _____

(08/2005)

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:

_____

_____

_____

_____

(03/2009)

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:_____

(03/2009)

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:_____

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

(03/2009)

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 THAT APPLY 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 LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE:www.insurance.ca.gov.**
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 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'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date:_____
Insured:_____