



Alarm Installation & Monitoring Application***

***Liquidated damage clause (limit of liability) is required for our program. Before proceeding with application, please make sure insured's contract contains this clause.

General Info (Complete For All Lines)

1. Name _____
(Complete name as it should appear on the policy including Inc., Corp., Ltd., Etc.)

2. Physical Address _____
No. Street City County State Zip Code

3. Please make certain additional locations are on ACORD forms.

4. Inspection Contact _____ Phone () _____
Audit Contact _____ Phone () _____
Claims Contact _____ Phone () _____

5. Telephone () _____ Fax () _____

6. Website _____ FEIN _____

7. Date established _____ License No. _____ Sole Proprietor Partnership
 Corporation Other

8. Policy proposed effective date _____ to _____

9. Current coverage expires/expired on _____

10. Check limit of liability desired: \$300,000 \$500,000 \$1,000,000 Other _____

11. Deductible: \$1,000 \$2,500 \$5,000 Other _____

12. Applicant Classification: _____% Security Service _____% Investigations
_____% Alarm Service and Monitoring _____% Consulting

13. Estimated annual a. Sales \$ _____ b. Payroll \$ _____

14. Operations of applicant (show sales for each – total shown should equal sales in question 13a)

A	Burglar & fire alarm installation – residential	A	\$
B	Burglar & fire alarm installation – commercial	B	\$
C	Burglar & fire alarm monitoring operations	C	\$
D	Medical emergency/ Nurse Call systems installation & monitoring	D	\$
E	Home detention or penal/correctional/prisons/jail systems installation & monitoring	E	\$
F	C.C.T.V. installation/ service/ repair	F	\$
G	Access control/ card entry systems	G	\$
H	Retail sales of equipment	H	\$
I	Fire extinguisher servicing/ installation/ testing/ repair	I	\$
J	Automatic sprinkler systems servicing/ installation/ testing/ repair	J	\$
K	Other – Describe:	K	\$

15. Does the insured install/service and/or repair alarms aboard aircrafts, automobiles, mobile equipment, boats and yachts? Yes No
If yes, please describe _____
-
16. Is the monitoring subcontracted out or handled by a third party? Yes No
a. If yes, what is the amount? _____
-
17. Is there any other work subcontracted out? Yes No
a. If yes, what is the cost _____
-
18. Does the applicant do any manufacturing? Yes No
19. Does the applicant sell anything under its own label? Yes No
20. If the answer to question 17 and/or 18 is yes, please explain _____
-
21. Are certificates of insurance obtained from ALL subcontractors? Yes No
22. Is named insured added as an additional insured on subcontractor's policy? Yes No
23. Does the applicant have his own contract? Yes No
a. If yes, please attach **copy of usual performance contract with client**
b. If no, whose contract is signed at installation? _____
-
24. Does the applicant limit his liability to a stated dollar amount (liquidated damages on his standard alarm contract with his client)? Yes No
a. If yes, what is maximum limit allowed? _____
b. **Please attach copy of contract**
-
25. Does the contract offer the option to buy back coverage? Yes No
a. If yes, what is maximum limit allowed? _____
b. And, what percentage (%) of the contracts have higher liquidated damage limits? _____
-
26. Total number of subscribers:
a. including central station subscribers _____
b. including central station subscribers under contract _____
-
27. Do you respond to your alarms? Yes No
If yes, are response runners armed? Yes No
-
28. Will you service a system that you did not install? Yes No
-
29. What specific warranties do you give on an outright sale? _____
-
-
30. Total number of employees: _____ Full Time
_____ Part Time
-
31. Does the applicant have a training program? Yes No
If yes, please describe _____
-
-
32. Describe screening procedures for prospective employees: _____
-
-
33. Does the applicant lease employees? Yes No

Additional Coverages

CHECK ALL THAT APPLY

Additional Insureds _____ Individual _____ Blanket
 Waiver of Subrogation _____ Individual _____ Blanket
 Primary Wording _____ Individual _____ Blanket
 Per Project Aggregate _____ Employee Benefits Liability _____
 Stop Gap _____ Hired/Non-owned Auto _____

Current General Liability Information

1. Please provide name of carriers, premiums paid, limits, sales, deductibles, and loss runs for the past 5 years.

	YR - _____	YR - _____	YR - _____	YR - _____	YR - _____
Carrier					
Premium					
Sales					
Ded/SIR					
Losses					

2. Has any company canceled or declined to renew in the past 5 years? Yes No

If yes, please explain: _____

3. Has the insured ever had a lapse in coverage? Yes No

If yes, please explain: _____

Claim Information

1. Make sure to attach 5 years of currently valued loss runs. (Valued no more than 3 months from date of application.)

2. Do you require staff to report all unusual incidents and are all incident reports reviewed by Management? Yes No

3. Do you have any knowledge concerning any incidents that have occurred prior to the date of this application that may give rise to a future claim? Yes No

ALL RISKS, LTD.

NOTICE TO APPLICANTS: THIS APPLICATION MUST BE COMPLETED IN FULL AS THE QUOTE WILL BE BASED SOLEY ON THE INFORMATION PROVIDED, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME BY SIGNING THIS APPLICATION, THE SIGNOR WARRANTS THAT TO THEIR BEST KNOWLEDGE ALL INFORMATION GIVEN IS TRUE AND ACCURATE.

 Name (type or print) Signature Date

NOTICE TO PRODUCERS: THE PRODUCER HEREBY WARRANTS THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF THEIR KNOWLEDGE.

 Name (type or print) Signature Date License #

Optional Coverages

(please attach an ACORD application)

- | | | |
|--|---|--|
| <input type="checkbox"/> Property | <input type="checkbox"/> Contractors Equipment | <input type="checkbox"/> EDP |
| <input type="checkbox"/> Business Auto | <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> Umbrella/Excess |
| <input type="checkbox"/> Crime/Employee Dishonesty | <input type="checkbox"/> Employment Related Practices | |

Umbrella/Excess Questionnaire

(Please complete only if desired.)

Explain all "Yes" responses.

1. With the exception of leinholders, are any vehicles not solely owned by and registered to the applicant? Yes No
2. Do over 50% of the employees use their autos in the business? Yes No
3. Is there a vehicle maintenance program in operation? Yes No
4. Are any vehicles leased to others? Yes No
5. Are any vehicles customized, altered or have special equipment? Yes No
6. Do operations involve transporting hazardous material? Yes No
7. Any vehicles used by family members or non employees?
If so, please identify in remarks. Yes No
8. Does the applicant obtain MVR verifications? Yes No
9. Does the applicant have a specific driver recruiting method? Yes No
10. Are any drivers not covered by Workers Compensation? Yes No
11. Any vehicles owned but not scheduled on this application? Yes No

Remarks:

WORKERS' COMPENSATION

Information Required with Submission: (Please attach)

1. ACORD Workers' Compensation application
2. Financials for accounts over \$100,000
3. Insurance Carrier Premium and Loss statements which are currently valued (5 years required).
4. Drivers schedule: Names, Dates of Birth & Driver's License Number required.
5. Experience Mod. Worksheet
6. Risk Identification Number for the NCCI or Appropriate State Rating Bureau or State Fund:

1. Annual employee turnover rate _____%

2. Is the current coverage now in Assigned Risk, State Fund or Voluntary Market? Yes No

3. Has any insurance carrier canceled or refused to renew within the past 3 years? Yes No
If yes, please explain _____

4. Do you report all WC claims, regardless of payment having been made on the claim? Yes No
If no, please explain: _____

5. Employee Benefits Program: Group Medical 401K Other _____

Describe your Employee Benefits Program:

6. Do you have a transitional duty (light duty) program? Yes No
If yes, describe: _____

7. Who is responsible for safety? _____

8. Do you have a formal safety committee? Yes No
If yes, how frequently does it meet and who attends? _____

9. Do you have a medical or physicians network in place for worker's comp. claims? Yes No
If yes, describe in detail: _____

10. Auto/Fleet Exposures (Complete if auto is not submitted with the workers' compensation.)

a. Number of Drivers: _____

b. Number of and types of vehicles: _____

c. How are vehicles used? _____

d. What time of the day are vehicles used? _____

e. Who is allowed to drive vehicles? _____

f. How often are MVR's pulled on all drivers? _____

g. Describe MVR policy as it relates to vehicle usage: _____

h. Are vehicles taken home? Yes No

If yes, what limitations are in place for personal use? _____

i. Is there a maintenance program? Yes No

WAIVER SUBROGATION – Provide the names, addresses & class codes/payroll of all contracts requiring a waiver of subrogation.

Crime/Employee Dishonesty Questionnaire

(Please complete only if desired.)

1. Do you have an audited financial statement prepared annually? Yes No

2. Are internal financial statements prepared? Yes No

If yes, how often are they reviewed by the owner? _____

3. Describe your "Separation of Duties" and "Countersignature" procedures: _____

4. Indicate the number of employees who handle, have custody or maintain records of money, securities or other property: _____

5. Are officer-shareholders active in the day to day oversight of business operations? Yes No

6. Do employees who reconcile the bank statement also:
Make deposits? Yes No Make withdrawals? Yes No Sign Checks? Yes No

7. Is countersignature of checks required? Yes No
If yes, what is the dual signing limit? _____

8. Is segregation of duties practiced in the following areas:
Inventory management? Yes No Wire transfer receipts and payments? Yes No
Purchase order approval and payment? Yes No Vendor approval? Yes No
Oversight of blank check stock? Yes No Payroll? Yes No
Retail checks and Credit Card receipts? Yes No Cash receipts? Yes No

9. Are all incoming checks stamped "for deposit only" immediately upon receipt? Yes No

10. Are inventory records computerized? Yes No
Is a physical count of inventory conducted at least annually? Yes No

11. Are the duties of computer programmers and operators separated? Yes No

12. Are computer passwords changed frequently? Yes No

13. For new employees, do you perform any of the following types of background checks:
Prior employment? Yes No Education? Yes No Criminal history? Yes No
Drug testing? Yes No Credit history? Yes No

14. Are the controls indicated in 5-13 above imposed at all locations? Yes No
If no, please explain exceptions.

15. List all Crime/Fidelity Losses in the last three years:

16. Please indicate the coverages, limits, and deductibles desired:
 \$25,000 limit, \$1,000 deductible
 \$50,000 limit, \$1,500 deductible
 \$75,000 limit, \$2,500 deductible
 \$100,000 limit, \$5,000 deductible
 Other _____

17. List any qualified benefit plans

18. Are you interested in Fiduciary Liability Coverage? Yes No
If yes, please attach Form 5500's for each plan to be covered.

19. Current Fidelity Carrier? _____ Premium? _____
Limits? _____ Deductible? _____