



Private Investigators General Liability & Renewal Application

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

2. Address _____
 No. Street City County State Zip

3. Person To Contact _____ Title _____

4. Telephone _____ Fax _____ FEIN _____

5. Date Established _____ License Number _____ Sole Proprietor Partnership Corp.

6. Policy Period Requested: from _____ to _____ Limit Requested _____

Deductible Requested \$250 \$500 \$1,000 \$2,500 (Applies to all losses including defense)

7. # of employees, including you, who perform investigative service(s) _____ Full Time _____ Part Time

Annual Revenue (sales) Current Policy Year _____ Previous Policy Year _____
 (next 12 months) (last 12 months)

Annual Payroll: Current Policy Year _____ Previous Policy Year _____
 (next 12 months) (last 12 months)

Annual Paid to Subs: Current Policy Year _____ Previous Policy Year _____
 (next 12 months) (last 12 months)

8. Do you use a standard contract or agreement for all investigative services provided? Yes No
 If yes, please provide a sample copy of your standard contract or agreement.

9. Services provided: Please check services that you now provide or would provide if requested.

- | | | |
|---|---|--|
| <input type="checkbox"/> Narcotics Surveillance | <input type="checkbox"/> Online Searches | <input type="checkbox"/> Undercover Operatives |
| <input type="checkbox"/> Auto Repossession | <input type="checkbox"/> Accident Reconstruction | <input type="checkbox"/> Guard Service/Property Protection |
| <input type="checkbox"/> Bodyguard/Exec. Protection | <input type="checkbox"/> Arson Investigations (C&O) | <input type="checkbox"/> Process Service |
| <input type="checkbox"/> Store Detective (Arrests) | <input type="checkbox"/> Attorney/Legal Investigations | <input type="checkbox"/> Subpoena Service |
| <input type="checkbox"/> Polygraph/PSE Exams | <input type="checkbox"/> Insurance Fraud Investigations | <input type="checkbox"/> Pre-employment Backgrounds |
| <input type="checkbox"/> Foreclosure Sales | <input type="checkbox"/> Locate People/Witnesses | <input type="checkbox"/> Electronic Countermeasures |
| <input type="checkbox"/> Bank Account Searches | <input type="checkbox"/> Domestic Surveillance | <input type="checkbox"/> Other (Describe) |
| <input type="checkbox"/> Asset Searches | | |

10. Are you a member of any professional organization? Yes No

If yes, please provide name(s) _____

11. Do you currently have insurance? Yes No If yes, name of carrier _____

If currently insured, annual premium _____ Deductible _____ Limits _____

If currently insured, is policy: Claims Made Form or Occurrence Form

12. Have you ever been sued or had any insurance claims? Yes No If yes, please explain

13. Do you or any of your employees carry a firearm? Yes No If yes, are they licensed? 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

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					

PROVIDE AND INCLUDE WITH THIS APPLICATION A LOSS RELEASE LETTER, AND LOSS LETTER IF YOU HAD NO CLAIMS OR LOSSES, A COPY OF THE DECLARATIONS AND RATING PAGE(S) FROM YOUR CURRENT POLICY, AND A RESUME OR PROFESSIONAL BIOGRAPHICAL SKETCH OF ALL PERSONS PERFORMING INVESTIGATIVE SERVICES FOR YOU/THIS COMPANY. ALL POLICIES ISSUED ARE SUBJECT TO A SATISFACTORY INSPECTION WITHIN 30 DAYS OF BINDING.

NOTICE TO APPLICANTS: THIS APPLICATION MUST BE COMPLETED IN FULL, AS THE QUOTE WILL BE BASED SOLELY 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 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. BY SIGNING THIS APPLICATION, THE SIGNOR REPRESENTS THAT, TO THE BEST OF THEIR KNOWLEDGE, ALL INFORMATION GIVEN IS TRUE AND ACCURATE.

 APPLICANT'S SIGNATURE

 TITLE

 DATE

WORKERS' COMPENSATION

Information Required with Submission: (Please attach)

1. ACORD Workers' Compensation application
2. Location Coding – see attached pages
3. Financials for accounts over \$100,000
4. Insurance Carrier Premium and Loss statements which are currently valued (5 years required).
5. Drivers schedule: Names, Dates of Birth & Driver's License Number required.
6. Experience Mod. Worksheet
7. 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.

