



ALL RISKS, LIMITED – National Specialty Programs
 10150 York Road, 5th Floor, Hunt Valley, MD 21030
 Toll Free: (800) 366-5810
 Fax: (410) 828-8179
 Contact us at: programs@allrisks.com
www.allrisks.com

Security Guard Application

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
 Consulting Alarm Service and Monitoring

13. In regards to your clients. Do you assume any duties not related to security, i.e. janitorial, maintenance, housekeeping, etc. If yes, please explain _____

14. Provide the names of your (5) five largest revenue producing clients, and a description of your duties.

15. Are the majority of your clients under contract? Yes No
 a. If yes, how many include hold harmless clauses? _____

b. Please include sample copies of your standard contracts and agreements.

16. Do you subcontract work? Yes No
 If yes, do you require certificates and/or proof of Errors & Omissions and Commercial General Liability Insurance? Yes No

17. Are you named as an additional insured on the subcontractor's policy? Yes No

SECURITY SERVICE/PATROL

1. What background do the principals of this organization have in the Security Industry?
 (Please attach resume) _____

2. Will the principals perform Guard/Investigative Operations? Yes No

3. Number of Supervisors _____ Describe duties of Supervisors: _____

4. Average number of guards per supervisor _____

5. Annual guard turnover rate _____

6. Training program consists of:

<input type="checkbox"/> Written Manual	<input type="checkbox"/> On Job	<input type="checkbox"/> CPR
<input type="checkbox"/> Report Writing	<input type="checkbox"/> Powers of arrest	<input type="checkbox"/> Films
<input type="checkbox"/> Firearms	<input type="checkbox"/> Classroom	<input type="checkbox"/> Other _____

Describe your training program: _____

7. Pre-employment screening procedures (check the following):

<input type="checkbox"/> Polygraph	<input type="checkbox"/> Prior Employer Contacted	<input type="checkbox"/> Criminal Background
<input type="checkbox"/> Drug Screening	<input type="checkbox"/> Fingerprint Check	<input type="checkbox"/> Driving Record
<input type="checkbox"/> Psychological Test	<input type="checkbox"/> Personal References	<input type="checkbox"/> Other _____

Describe your pre-employment screening procedures: _____

8. Total number of guard hours billed to client(s) annually:
 Unarmed _____ Armed _____

9. Total number of Guards:

	Full Time	Part Time
Unarmed		
Armed		
Supervisors		

10. Do you use any equipment or golf carts for patrol? Yes No
 If yes, how many? _____

11. Will the public be transported? Yes No
 If yes, are driving records checked on drivers? Yes No

12. Do you anticipate using dogs? *Must be leashed not to exceed 6ft. Yes No

a. If yes, number of dogs used with handlers _____ without handlers _____

b. And, for what purpose will the dogs be used?

<input type="checkbox"/> Bombs	<input type="checkbox"/> Drugs
<input type="checkbox"/> Airports	<input type="checkbox"/> Other _____

13. Are all armed employees licensed by the state to carry firearms? Yes No
 If yes, how often will they have to be re-certified? _____

14. Employee Pay scale (Hourly)

	Minimum	Maximum	Average
a. Supervisors			
b. Unarmed Guards			
c. Armed Guards			

15. Please provide Total Payroll and Billable Hours for the past five years:

	YR	YR	YR	YR	YR
Total Payroll					
Total Billable Hours					

-LIST ANNUAL PAYROLL SEPARATELY BY CATEGORY-

	ARMED PAYROLL	UNARMED PAYROLL
SUPERVISORY		
GUARD SERVICES		
• Airports (describe operations)_____		
• Banks or other financial institutions		
• Construction or Demolition Sites		
• Conventions		
• Escort Service/Body Guard Service		
• Fast Food Restaurants		
• Government Contracts (office building, courts, military base)		
• Hotels/Motels		
• Housing/Residential – Mid/High Income		
• Housing/Residential – Low Income/HUD		
• Industrial (warehouses, factories)		
• Institutions (schools, hospitals, other_____)		
• Liquor Establishments (bars, restaurants, other_____)		
• Malls/Theaters/Arcades		
• Office Buildings		
• Patrol Cars(alarm response, patrol, other_____)		
• Retail (parking lots, outside patrol, other_____)		
• Retail (shoplifting, surveillance, inside, other_____)		
• Special Events (sports, concerts, other_____)		
• Strike Work		
• Traffic Control		
• Utilities (water, electrical, nuclear)		
• Other- Describe _____		
TRANSPORTATION SERVICES		
• Armored Car		
• ATM Services		
• Courier (describe commodity transported)		
• Other- Describe _____		
PRIVATE INVESTIGATIONS		
• Auto Repossession		
• Bank Checks (pre-employment screening)		
• Body Guard Protection		
• Bounty Hunter		
• Computer Fraud		
• Criminal		
• Divorce/Domestic		
• Executive Protection		
• General Background Checks		
• Missing Persons		
• Polygraph		
• Process Serving		
• Psychological Stress Evaluator		
• Security Consultation		
• Other- Describe _____		
OTHER		
• Clerical		
• Outside Sales		
• Other- Describe _____		
TOTAL		

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					
Payroll					
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 which 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 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 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. 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.

If the Insured has no exposure to any of the High Profile Locations, please note "no exposure, and sign/date the form.

WCM Workers Compensation

High Profile locations / Exposures

Location / Exposure Type	Yes	Comments
Airports		
Public Transportation (Incl. rail, subway stations)		
Monuments & other historically significant loc.		
Convention Centers		
Major Religious Structures		
Stadiums, Arenas or Sporting Complexes		
Museums / Aquariums/ Zoos		
Stock Exchanges or Financial Centers		
Nationally Recognized Hospitals/ Medical Centers		
Amusement Parks (high profile)		
"Marquis" buildings		
Utilities / Energy Generating Stations		
Refineries / Fuel Depots		
Dams		
Hazardous Chemical Manufacturing		
Weapons / Defense Manufacturing		
Military Bases or Locations		
Major Casinos		
Mail Handling or Delivery		
High-Rise Buildings		
Tier 1: Nationally recognized (e.g., Sears Tower)		
Tier 2: Over 35 stories		
Tier 3: Between 20 and 35 stories		
Other Specialty Situations		
Example: Olympic Venues, other Special Events		

Signature: _____

Date: _____

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? _____