



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:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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:**

<u>Client Base:</u>	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	\$ _____	\$ _____	
<b>SUB-TOTAL:</b>	\$ _____	\$ _____	<b>TOTAL:</b> _____

(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: \_\_\_\_\_



**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](http://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: \_\_\_\_\_