

COVERX

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SOUTHFIELD, MI 48034

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www.coverx.com

Producer: _____

Address: _____

_____ Telephone: _____

Fax: _____

E-Mail / Web Address: _____

Proposed Effective Date: _____

Producer's Surplus Lines Lic #: _____

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 License State: _____

SL License No.: _____

SL License Expiration Date: _____

SL Licensee Name: _____

Affiliation with Producer (e.g., Owner, Executive Officer, Employee): _____

SL Licensee Agency Name (if Entity License): _____

SECURITY TRAINING SCHOOLS LIABILITY INSURANCE APPLICATION

1. Applicant's Legal & Trade Name: _____

2. Address: _____

Mailing Address (if different than above): _____

Additional Locations (if any): _____

3. Contact person for inspection/audit: _____ Telephone #: _____

4. Applicant is: Individual Corporation Partnership Other (Describe): _____

5. E-Mail Address and / or Website Address: _____

6. List any trade group affiliations: _____

7. How long have you owned this business? _____

8. How many years experience do you have in this field? _____

9. Are you involved in any other business operations? Yes No If Yes, please describe: _____

10. Indicate training environment (Classroom only, Hands-On physical training only, or both): _____

11. Will you have all students sign a Registration Form with a Student Assumption of Risk clause and Safety Rules?
 Yes No

13. Do you sign contracts with law enforcement or public entities, or private companies to perform training?
 Yes No
14. If yes, do you assume liability, indemnify, or agree to hold such parties harmless as to your training activities?
 Yes No
15. If you have employees or independent contractors doing training, indicate Screening Protocols:
 Prior Employment Check Drug Screening Personal Reference Psychological Testing
 Polygraph MVR Background Check
16. Do you hire any Independent Contractors to perform training on your behalf? Yes No
 If yes, are they a business with insurance, or 1099'd individuals without insurance, or both? : _____

If the IC is a business that carries insurance, you must be listed as an Additional Insured on their policy, evidenced by a current Certificate Of Insurance.

17. Are you ever required to name another party as an Additional Insured under your policy? Yes No
 If yes, please describe: (eg. landlord; lessor of building or other facility; lessor of equipment; etc.) _____

18. Are you ever asked by a law enforcement or public entity to list them as an Additional Insured under your policy?
 Yes No If yes, describe: _____

19. List any professional / occupational licenses held (by owners): _____

20. Please provide details of the nature of the training:

Claim / Loss History: If none, so state. Attach five (5) years currently valued loss runs with application, (if available).

Date	Description	Paid Amount	Open Reserves	Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Describe any additional incidents that have occurred that may result in a claim being made against your business. If none, so state:

Prior Policy Information:

Insurer	Policy Period	Limits	Premium	Basis	Deductible
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has any carrier cancelled or refused to renew? Yes No If Yes, please explain: _____

EXPOSURE INFORMATION:

Projected Gross Receipts for the current annual period: \$ _____

Number of Owners, Partners, Executive Officers involved in training activities or supervision: _____

Annual payroll for other employees who perform training or training supervision: \$ _____

Annual cost paid to ICs that perform training or training supervision: \$ _____
(Independent Contractors, either 1099'd individuals or those in business)

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. PE

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's authorized representative)

Applicant Date Producer Date

NOTE: This is an application only. Coverage is not in effect until bound by the Insurer.

CALIFORNIA 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 LINES” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT WHICH APPLIES 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 LINES INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST.**
- 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 THAT 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 FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Applicant: _____ **Title:** _____ **Date:** _____
(signed by Applicant's authorized representative)

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