

# QSR

www.qsr-insurance.com

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**IMPORTANT – To be completed by Producer:**

Name: \_\_\_\_\_

Producer Is:  Wholesaler  Retailer

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

If Renewal, Provide Current Policy No.: \_\_\_\_\_

**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 Licensee Agency Name: \_\_\_\_\_

SL License State: \_\_\_\_\_

SL License No.: \_\_\_\_\_

SL License Expiration Date: \_\_\_\_\_

SL Licensee Name (if not an Entity License): \_\_\_\_\_

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

## ALARM OPERATIONS GENERAL LIABILITY APPLICATION

1. Applicant: \_\_\_\_\_

2. Street Address: \_\_\_\_\_

Mailing Address (if different than above): \_\_\_\_\_

Additional Locations (if any):

a. \_\_\_\_\_

b. \_\_\_\_\_

c. If additional space is necessary, please provide additional worksheet.

3. Name of contact person for inspection/audit: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

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

5. Coverage: \_\_\_\_\_

6. Limits: \_\_\_\_\_ Each Occurrence/Aggregate Deductible: \_\_\_\_\_

7. Operations (use percent %): \_\_\_\_\_ Alarm \_\_\_\_\_ Safety Equipment \_\_\_\_\_ Other: \_\_\_\_\_

8. How long has Applicant owned this business? \_\_\_\_\_

9. How many years experience does Applicant have in this field? \_\_\_\_\_

10. Is Applicant involved in any other operations?  Yes  No If Yes, please describe: \_\_\_\_\_

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>

**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: \_\_\_\_\_

Does Applicant install or service safety equipment in nursing homes, medical, correctional or detention facilities?  Yes  No  
 Is Applicant covered under Broad Form Vendors coverage by manufacturer?  Yes  No  
 Does the Applicant install safety equipment in buildings over four (4) stories?  Yes  No  
 Does Applicant perform any work at facilities where explosives are handled or stored or at nuclear power plants?  Yes  No  
 If Yes, describe: \_\_\_\_\_  
 \_\_\_\_\_

**OTHER OPERATIONS – SECURITY RESPONSE**

Does Applicant provide security/patrol response to their customers if and when local Police/Fire/EMTs do not respond?  Yes  No  
 If Yes, are the responders employees, or are they hired/contracted for this service? \_\_\_\_\_  
 \_\_\_\_\_

If responders are not employees, does Applicant have a written contract with the security company that provides the response? \_\_\_\_\_  
 \_\_\_\_\_

If Applicant does have a contract with the security company, is either part holding the other harmless/providing indemnification?  
 Yes  No. If Yes, provide details: \_\_\_\_\_  
 \_\_\_\_\_

Do any employees or subcontractors carry firearms?  Yes  No

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. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**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 Date Producer Date