www.pmcinsurance.com
pmc-info@one80.com
(877) PMC-COMP

Security Services Supplemental Application
Workers' Compensation

Name: _____ Website: _____

Address: _____ Phone: _____

Contact for Inspection: _____ Title: _____

FEID: _____ ◯ Corporation ◯ Partnership ◯ Individual ◯ Other: _____

Proposed Effective Date: _____ Is Workers' Compensation coverage currently in force: ◯ Yes ◯ No

Mailing Address (if different from above): _____

Additional Office Locations: _____

Operations in any other states: ◯ Yes ◯ No If "Yes", please list states: _____

Where is audit to be made? _____ Audit Contact: _____

How long in the Security Business: _____ Years operating under this business name: _____

If in business less than three (3) years, please give details of owner's background in security industry of related fields:

_____

Total number of Security Employees: _____ Full Time: _____ Part Time: _____ Armed: _____ Unarmed: _____

Average guard hourly wage: _____ Minimum: _____ Maximum: _____

Number of guard hours billed annually: _____ Armed: _____ Unarmed: _____

How many employees are under age 21? _____ Full Time: _____ Part Time: _____

Describe duties and provide work schedule:

_____

How many employees are over age 65? _____ Full Time: _____ Part Time: _____

Describe duties and provide work schedule:

_____

Are employees covered by group medical insurance? ◯ Yes ◯ No

Number of dogs in operation? _____ ◯ Attended ◯ Unattended

Types of assignments involving use of dogs:

_____

Is applicant involved in any other operation? ◯ Yes ◯ No

If "Yes", please describe: _____

Regarding your clients, do you assume any duties not related to security (e.g. janitorial, maintenance, housekeeping, etc.)? ◯ Yes ◯ No

If "Yes", please describe: _____

Do you maintain general liability insurance? ◯ Yes ◯ No Carrier: _____ Expiration Date: _____

List all clients to whom you assign armed personnel and their duties:

_____

Describe your training programs:

_____

Indicate your pre-employment screening procedures:

- ☐ Fingerprint
- ☐ Criminal Background
- ☐ Drug Screening
- ☐ Motor Vehicle Report
- ☐ Employment References
- ☐ Personal References
- ☐ Psychological Testing
- ☐ Employment Conditional Physicals
- ☐ Other: _____

Does the applicant subcontract work to others? ◯ Yes ◯ No

Are certificates of Insurance evidencing Workers' Compensation coverage required from subcontractors? ◯ Yes ◯ No

Number of independent contractors: _____ Armed: _____ Unarmed: _____

Are any Waivers of Subrogation Provided? ◯ Yes ◯ No

If "Yes", how many clients require waivers? _____

Does the applicant own or use airplanes in business? ◯ Yes ◯ No

If "Yes", **attach** aviation questionnaire

Does applicant conduct any operations on dockside or shipboard? ◯ Yes ◯ No

If "Yes", please describe in detail:

_____

Does applicant own any autos used in business? ◯ Yes ◯ No

If "Yes", number of company owned vehicles: _____

Other than travelling to and from work, do any employees use vehicles in the course of their employment? ◯ Yes ◯ No

If "Yes", indicate type and number of vehicles below:

Employee-owned vehicles: ◯ Yes ◯ No Number: _____

Bicycles: ◯ Yes ◯ No Number: _____

Client Owned Vehicles ◯ Yes ◯ No Number: _____

Golf Carts or Cushmans ◯ Yes ◯ No Number: _____

How are they used in business?

_____

Any emergency response? ◯ Yes ◯ No

Do you provide or arrange for transportation of employees to or from any site? ◯ Yes ◯ No

If "Yes", please describe: _____

INSURANCE HISTORY

Is coverage now in Assigned Risk Pool? ◯ Yes ◯ No Current Policy Number: _____

Paid and Reserved: _____ Number of Claims: _____

	Policy Period	Name of Insurer	Premium	Losses	Claims
Expiring:					
1st Prior:					
2nd Prior:					
3rd Prior:					
4th Prior:					

Expiring Experience Modification: _____ New Experience Modification: _____

Normal Anniversary Rating Date (N.A.R.): _____

Has there been a name change during the past three (3) years ◯ Yes ◯ No

If "Yes", please give previous names and date of change:

Has any insurer canceled or refused to renew coverage within the past three (3) years? (Not applicable in OR, ME, NE) ◯ Yes ◯ No

If "Yes", please explain: _____

Are you in debt to any broker, agent, or insurance company for any unpaid premiums for Workers' Compensation coverage or audits? ◯ Yes ◯ No

If "Yes", please explain: _____

List any individual claims over $5,000

Date of Accident	Name of Employee	Open or Closed	Description of Accident	Amount Paid or Reserved	Current Employment Status

Estimated Annual Payrolls

List payroll by category: (if operating in more than one state, please attach breakdown by state)

SECURITY GUARDS CLIENTS SERVICES

	Armed Payroll	Unarmed Payroll
Airports……..		
Retail (stores, markets, etc.)…….		
Industrial (warehouses, factories, utilities, etc……		
Schools (type): _____		
Hospitals……		
Special Events (sports, concerts, etc.)……..		
Trade Shows or Conventions……		
Liquor Establishments (stores, bars, restaurants, etc.)……		
Fast Food Establishments……		
Patrol Cars……		
Construction or Demolition Sites……..		
Housing – Low Income……...		
Housing – Mid to High Income……..		
Housing Authorities……		
Traffic Control, Direction or Flagmen……		
Hotels / Motels……		
Banks……		
Office Buildings……		
Government Contracts (specify): _____		
Detention Centers (Criminal or Immigration) including transport….		
Strike Work……...		
Cannabis:		
a). Dispensary……		
b). Extraction……..		
c). Harvesting…….		
Other (explain): _____		

PRIVATE INVESTIGATION

	Armed Payroll	Unarmed Payroll
Credit or pre-employment……..		
Insurance / Legal……		
Domestic……..……		
Undercover..……		
Auto Repossessions……..…….		
Computer……..……		
Shopping Service (observation only)……		
Shoplifting Surveillance (observation and detention)……		

OTHER

Executive Protection……		
Courier – Money or Valuables……..		
Courier – (explain):		
Other – (explain):		

GUARD / INVESTIGATION TOTALS……	$ 0.00	$ 0.00
ALARM OPERATIONS: INSTALLATION REPAIR……		
CLERICAL……..		
OUTSIDE SALES……..		

OWNERSHIP DATA
(List owners, partners, officers, and/or relatives to be included or excluded):

#	NAME	TITLE	OWNERSHIP %	DUTIES	INCL/EXCL	CLASS CODE	REMUNERATION*
1							
2							
3							
4							
5							

***Were these payrolls included in the estimated payrolls on Page 3?** ◯ Yes ◯ No

Requested Employer's Liability Limits:		
$		EACH ACCIDENT
$		DISEASE – POLICY LIMIT
$		DISEASE – EACH EMPLOYEE

Additional Comments:

Provided by: ☐ Insured ☐ Submitting Producer

The undersigned hereby makes application for insurance. This application is subject to the conditions and agreements as stated herein. The undersigned applicant hereby expressly agrees that the insurance applied for herein shall not be effective until such application is approved at the home office of the insurance company and shall expire or otherwise terminate in accordance with the policy provisions.

Signature of Applicant _____ Title _____ Date _____

Notice to Applicants: This application must be completed in full as the insurance company will rely on the information provided to prepare a premium quotation or to offer coverage. Furnishing false or misleading information, or concealing information concerning any material fact, may void insurance coverage, and may subject the individual to criminal prosecution.

PRODUCER'S CERTIFICATION
The producer also certifies that the information given, including premium information, is true to the best of his/her knowledge and belief.

Producer: Name (type or print) _____ Signature _____ Date _____ License No. _____