

This form must be completed for each new policy and at the beginning of each premium period for renewal policies.

**APPLICATION FOR A  
CRIME PROTECTION POLICY  
FOR MERCANTILE ENTITIES**

Application is hereby made by \_\_\_\_\_

(Please list all insureds, including Employee Benefit Plans)

Principal Address \_\_\_\_\_

(Number) (Street) (City) (State) (Zip Code)  
for a (check the appropriate box): Discovery , Loss Sustained  \_\_\_\_\_ Crime Protection Policy  
(primary, excess, contributing)

with:

**INSURING AGREEMENTS, LIMITS OF INSURANCE AND DEDUCTIBLES**

<u>Insuring Agreement</u>	<u>Limit of Insurance</u>	<u>Deductible Amount</u>
1. Employee Dishonesty	\$	\$
2. Forgery or Alteration	\$	\$
3. Inside the Premises	\$	\$
4. Outside the Premises	\$	\$
5. Computer Fraud	\$	\$
6. Money Orders and Counterfeit Paper Currency	\$	\$
Insuring Agreements added by Endorsement		
7. Loss of Clients' Property	\$	\$
8. Funds Transfer Fraud	\$	\$

to become effective or to be continued as of 12:01 a.m. on \_\_\_\_\_ to 12:01 a.m. on \_\_\_\_\_  
Premium payable (check the appropriate box): Annual , Three year Prepaid , Three equal annual installments   
Other Coverage Amendments (Endorsements) \_\_\_\_\_

**1. Description of your organization**

- (a) Are you a (check the appropriate box): Proprietorship , Partnership , Corporation ,  
Other  \_\_\_\_\_ .
- (b) Date your business was established: \_\_\_\_\_
- (c) Classify your predominant activity: Manufacturer , Processor , Wholesaler , Distributor , Retailer ,  
Servicer , Other  \_\_\_\_\_
- (d) Describe the products or services of your predominant business or activity \_\_\_\_\_
- (e) Has there been any change in ownership or management within the past three years? Yes  No   
If "Yes", explain \_\_\_\_\_

**2. Audit Procedures**

- (a) Is there an audit by a CPA, public accountant or equivalent, independent of your organization? Yes  No   
If "Yes", how often (check the appropriate box): Quarterly , Semi-Annually , Annually
- (b) Name and address of person performing audit: \_\_\_\_\_
- (c) Are all locations audited? Yes  No
- (d) Is the audit made in accordance with generally accepted auditing standards and so certified? Yes  No   
If "No", indicate the scope of service (check the appropriate box): Review , Compilation   
Other \_\_\_\_\_
- (e) Is the report rendered directly to the Owner, Partners or Directors? Yes  No
- (f) Date of completion of last audit of: Cash and Accounts \_\_\_\_\_ Inventory \_\_\_\_\_
- (g) Were any discrepancies or loose practices commented upon in the audit? Yes  No   
If "Yes", submit a copy of the auditor's comments.

- (h) Is there an internal audit by an Internal Audit Department under the control of an employee who is a certified public accountant or equivalent? Yes  No   
 If "Yes", are the reports rendered directly to the Owner, Partners or Directors? Yes  No

**3. Internal Controls**

**Bank Accounts:**

- (a) Are bank accounts reconciled monthly? Yes  No   
 (b) Are bank accounts reconciled by someone not authorized to deposit or withdraw? Yes  No   
 If "No", explain \_\_\_\_\_  
 (c) Is countersignature of all checks required? Yes  No   
 Above what amount? \$ \_\_\_\_\_  
 (d) Does supporting documentation accompany all checks to be signed? Yes  No   
 (e) Do you maintain a list of approved vendors? Yes  No   
 (f) Are securities subject to the joint control of two or more employees? Yes  No   
 (g) Explain your screening procedures for new employees \_\_\_\_\_

**4. Prior Insurance**

- (a) Has any similar insurance been declined or canceled during the past three years? Yes  No   
 If "Yes", explain \_\_\_\_\_  
 (b) Prior insurance to be superseded Check here if none

Policy Number	Discovery or Loss Sustained	Effective Date	Expiration Date	Limit of Insurance	Name of Insurance Company
				\$	

- (c) List below all losses sustained during the past three years that were caused by: employee dishonesty, forgery, theft of money or securities on the premises, robbery or safe burglary of other property on the premises, or robbery of money, securities or other property in the custody of a messenger. Please list all losses, whether reimbursed or not. Check if none

Date of Loss	Type of Loss	Amount Recovered from Insurance	Amount Recovered from Other than Insurance	Amount of Loss Pending	Location of Loss
		\$	\$	\$	

**5. Rating Data for Insuring Agreements 1, 2 and 5**

(a) Classification of Employees:

(1) Number of Officers: \_\_\_\_\_

(2) List the number of employees in the following classifications:

Number of		
_____	Accountants and Asst.	Credit Clerks and Managers
_____	Accountants	Custodians
_____	Adjusters	Delivery Persons
_____	Administrators and Asst.	Detectives
_____	Administrators	Drivers and Drivers' Helpers
_____	Appraisers and Clerks acting as Appraisers	Food and Beverage Vendors
_____	Attorneys	Food and Beverage Service Personnel that order food
_____	Auditors and Asst. Auditors	Freight Handlers
_____	Bartenders	Games of Chance Dealers
_____	Bookkeepers	Hotel Front Desk Personnel
_____	Bus Drivers	Janitors
_____	Buyers or Asst. Buyers	Managers and Asst. Managers
_____	Cashiers and Asst. Cashiers	Medical Directors
_____	Chairpersons	Messengers, outside
_____	Chauffeurs	Meter Readers who collect
_____	Collectors	Payroll Clerks
_____	Comptrollers and Asst.	Pharmacists
_____	Comptrollers	Purchasing Agents or Asst. Purchasing Agents
		Receiving Clerks
		Retail Services Counter Personnel
		Salespeople
		Security Personnel
		Service Station Attendants
		Shipping Clerks
		Stock Clerks
		Storeroom Personnel
		Superintendents and Asst. Superintendents
		Supervisors and Asst. Supervisors
		Systems Analysts having access to financial management computer system
		Taxi Drivers
		Treasurer and Asst. Treasurer
		Truck Drivers
		Warehouse Personnel

(3) Number of all employees (not listed above) who handle, have custody or maintain records of money, securities or other property: \_\_\_\_\_

(4) Number of all other employees \_\_\_\_\_

(b) Number of additional locations other than the head office: \_\_\_\_\_

**6. Rating Data for Insuring Agreement 7**

List the number of employees who handle, have custody of, maintain records of or have access to money, securities or other property owned by your clients. \_\_\_\_\_

**7. Rating Data for Insuring Agreements 3 and 4**

(a) Indicate the number of locations \_\_\_\_\_

(b) Indicate the number of outside messengers \_\_\_\_\_

(c) Do guards accompany each messenger? Yes  No

(d) Are your premises secured by watchpersons? Yes  No

(e) Are your premises secured by an alarm system? Yes  No

Please provide details \_\_\_\_\_

(f) Is a safe used at all locations? Yes  No

Please provide details \_\_\_\_\_

(g) What other measures have been taken to provide physical protection (private conveyance, messenger bags, safe alarms, etc.)?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8. General Information**

Business Hours	Av. # of Employees on Duty	Frequency of Deposits	Night Depository Used?	Annual Gross sales or receipts for last fiscal yr.	Other Information
				\$	

**9. Coverage Amendments**

(a) Insuring Agreement 1

(1) If the deductible is limited to specified positions, list the positions and the number of employees occupying those positions:

<u>Number of Employees</u>	<u>Positions</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(2) If insurance is desired on any of your appointed or elected agents, whether they be persons, partnerships or corporations performing any act or service in connection with the ordinary conduct of your business, complete the following:

<u>Capacity in Which Each Agent Serves</u>	<u>Limit of Insurance</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

(3) If Insurance is desired on any of your partners, please indicate the number of partners to be covered \_\_\_\_\_

(4) If blanket excess limits of insurance are desired on any of your joint insureds, complete the following:

<u>Joint Insured(s)</u>	<u>Number of Employees</u>	<u>Excess Limit of Insurance</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

(5) If excess limits of insurance are desired on any of your employees on either a name schedule or position basis, complete the following:

Name Schedule Coverage	Position Schedule Coverage			
Names of Covered Employee(s)	Title(s) of Covered Position(s)	Location of Covered Positions	Number of Employees in Each Position	Excess Limit of Insurance for Each Employee
				\$

(b) Insuring Agreement 2

If insurance is desired, complete the following:

(1) Credit, Debit or Charge Card Instruments

Covered Instruments (check the appropriate box):  
include  or are limited to  credit, debit or charge cards  
issued to you or any employee for business purposes

Number of  
Cardholders

Limit  
of Insurance

\_\_\_\_\_ \$ \_\_\_\_\_

(2) Warehouse Receipts:

Covered instruments (check the appropriate box):  
include  or are limited to  warehouse receipts and withdrawal orders

\$ \_\_\_\_\_

(3) Personal Accounts of your officers or partners:

Names(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_  
\$ \_\_\_\_\_

(c) Insuring Agreements 3 and 4

(1) Increased or Reduced Limits

a) If an increased limit is desired for a specified period, indicate:

Insuring Agreement 3

Insuring Agreement 4

Limit of  
Insurance

Specified  
Period

\$ \_\_\_\_\_

\$ \_\_\_\_\_

b) If a decreased limit is desired while the business is closed and  
a custodian is not on duty, indicate:

\$ \_\_\_\_\_

c) If a reduced limit is desired for designated premises, messengers  
or armored motor vehicle companies, complete the following:

Address of Premises	Names of Messengers	Names of Armored Motor Vehicle Companies	Limit of Insurance
			\$ _____

(2) Schedule Coverage

If schedule coverage is desired, complete the following:

Address of Premises	Insuring Agreement 3 Limit of Insurance	Insuring Agreement 4 Limit of Insurance	Number of Armored Motor Vehicles	Number of Messengers
	\$ _____	\$ _____		

(d) Covered Property in Custody of Designated Agent

If coverage for property while in the custody of a designated agent is desired, please indicate:

<u>Name of Agent</u>	<u>Value of Property in Custody of Agent</u>
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

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**10. The Insured represents that the information furnished in this application is complete, true and correct. Any misrepresentation, omission, concealment or incorrect statement of a material fact, in this application or otherwise, shall be grounds for the rescission of any coverage issued on reliance upon such information.**

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
(Insured) By \_\_\_\_\_  
(Name and Title)