

# Bind Request

Agent Information

Name:

Date Prepared:

Address:

Insured's

Name:

DBA:

Prepared By:

Phone: (     )     )

Fax: (     )     )

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To: Commodore Insurance Services, Inc.  
Attention:

Please Bind the Policy for the above Insured.

Effective Date:

Additional Comments

**This is not a self-rating program. Rates are made available as a guideline to determine competitiveness with Insured's current coverage. We understand that coverage for this risk is not bound until reviewed and approved by the company underwriter.**

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

# DILIGENT SEARCH REPORT

(Please Refer to the Instructions on Page 3 of This Form)

1. \_\_\_\_\_ hereby submits that he/she is:  
(Full Name of Individual)
- (A) Duly licensed under the California Department of Insurance license number \_\_\_\_\_ ;
- OR (B) Duly licensed and authorized to act as an endorsee on the organizational license of \_\_\_\_\_ , California Department of Insurance license number \_\_\_\_\_ ;  
(Name of Organization)
- and (C) that he/she or said organizational licensee was engaged by the insured named herein, or the insured's broker, to obtain insurance as described in this report;
- and (D) is the licensee who performed or supervised this diligent search.
- 

2. (A) Name of Insured \_\_\_\_\_
- (B) Address of Insured \_\_\_\_\_  
(Street and Number)
- (City) (State) (Zip Code)
- (C) Description of Risk \_\_\_\_\_  
(e.g. Laundromat, liquor store, ...NOT TYPE OF COVERAGE)
- (D) Location of Risk \_\_\_\_\_  
(Street and Number)
- (City) (State) (Zip Code)
- (E) Type of Insurance coverage \_\_\_\_\_  
(Enter Appropriate Code Number from Pg. 3)
- 

3. If **Private Passenger Automobile Liability Insurance** is identified on line 2(E), complete the following:
- (A) Does the insured qualify as a "Good Driver" under Section 1861.025 of the California Insurance Code?  
(CHECK ONE) YES  NO
- (B) Does the coverage that you have placed include, in whole or in part, the limits of coverage provided under the California Automobile Assigned Risk Plan (CAARP)? (CHECK ONE) YES  NO
- (C) If YES, has this risk been submitted to and found to be ineligible by CAARP?  
(CHECK ONE) YES  NO   
If your answer is NO, then this coverage cannot be placed with a non-admitted insurer.  
(See Insurance Code section 1763.5)
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4. If **Health Insurance** is identified on line 2(E), does the insured qualify as a "Small Employer" under Section 10700(x) of the California Insurance Code? (CHECK ONE) YES  NO
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5. If this insurance was placed pursuant to Section 125 *et seq.* of the California Insurance Code governing transactions with **risk purchasing groups** authorized by the Federal Liability Risk Retention Act of 1986, complete the following:

(A) Provide the name and address of the purchasing group of which the insured is a member

\_\_\_\_\_

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6. (A) **Describe** the diligent efforts made to place this coverage with admitted insurers and describe how the search was performed (please add additional pages if necessary):

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

(B) If search was performed by someone **other** than the person named on line 1, please provide full name of that individual:

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7. (A) Was the risk described in Section 2 submitted by you or by someone under your supervision to at least (3) insurers that are admitted in California and who actually write the type of insurance described on lines 2(C) and 2(E)? **(CHECK ONE)** YES  NO

(B) If **YES**, please complete **ALL** sections of the following table; if **NO**, skip to Section 8:

Full Name of Admitted Company	First and Last Name of Company Representative AND Telephone Number	Check if Employee (E) or Agent (A)	Month, Year of Declination	Declination Code*
1.	( ) - or "Online Declination" Website _____	E <input type="checkbox"/> A <input type="checkbox"/>	/	
2.	( ) - or "Online Declination" Website _____	E <input type="checkbox"/> A <input type="checkbox"/>	/	
3.	( ) - or "Online Declination" Website _____	E <input type="checkbox"/> A <input type="checkbox"/>	/	

\* Declination Codes: 1 – Company's capacity reached 2 – underwriting reason 3 – refused to state 4 - other

8. If 7(A) was answered **NO**, complete the following:

(A) Did you determine that fewer than 3 admitted insurers actually write the type of insurance described on lines 2(C) and 2(E)? **(CHECK ONE)** YES  NO

(B) If **NO**, please explain in detail why the risk was submitted to less than three admitted insurers in California that write this type of insurance.

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(C) If **YES**, please describe how you made this determination. \_\_\_\_\_

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The undersigned licensee hereby certifies that this report is true and correct, and that this risk is not being placed with a non- admitted insurer for the sole purpose of securing a rate or premium lower than the lowest rate or premium available from an admitted insurer.

\_\_\_\_\_  
(Signature of Licensee Named on Line 1)

\_\_\_\_\_  
(Date)

## INSTRUCTIONS

**SECTION 1:** Please provide the full name of the licensed individual who performed or supervised the diligent search. If the search was performed under the individual's license number, enter his/her license number in section (A) or if the individual was authorized as an endorsee under an organizational license, enter the name of the organization and its license number in section (B).

**SECTION 6:** Please provide a complete response on section (A). Note: The Insurance Commissioner or his designee may require the surplus line broker to conduct a further or additional search among admitted insurers for similar placements in the future. [California Insurance Code Section 1763(b)] An incomplete response may unnecessarily result in a request for a further search to be conducted. If the individual named on line 1 did not perform the diligent search, please provide the full name of the individual who performed the search on section (B).

**SECTION 7(B):** To avoid mis-identification among insurers with similar names, please provide the complete name of the admitted insurer as listed in the CDI Official Publication of Admitted Companies.

Insurer group names, such as Cigna Group, Chubb Group, California Ins. Group, Hartford Group, etc., are acceptable if the person performing the search verifies that the representative of the group, who declines the risk, does in fact represent an admitted insurer in the group that actually writes the particular type of insurance being sought.

**IMPORTANT:** Persons who are licensed only as an agent may only submit a risk to admitted insurers that have appointed them as their agent. Agents are not authorized to offer a risk to admitted insurers for which they are not appointed agents. A search which is limited to only those companies that have appointed the agent may not necessarily constitute a diligent search of the admitted market.

**WHAT TO FILE:** This report must be filed as an attachment to the Report of Placement. (CDI Form SL-1).

**WHERE TO FILE:** The SL-1 and this report are to be filed by the surplus line broker with The Surplus Line Association of California within 60 days of placement of coverage with non-admitted insurer(s).

**MULTIPLE LICENSEES CONDUCTING SEARCH:** If two or more licensees conduct a diligent search of admitted insurers, then each licensee must complete a diligent search report (CDI Form SL-2). All such reports should be attached to the SL-1.

### CODE TYPE OF INSURANCE

050	Auto Liability-Private
051	Auto Liability-Commercial
100	Auto Physical Damage-Private
101	Auto Physical Damage-Commercial
150	Crime
151	Crime-Kidnap & Ransom
200	Combined Auto Liability & P.D.-Private
201	Combined Auto Liability & P.D.-Comm.
300	Excess Liability (Incl. Umbrella)
350	Fidelity Surety & Bonds-Bonds
351	Fidelity Surety & Bonds-Fidelity
400	Fire-Single Family Dwelling, Duplex
401	Fire-Commercial
402	Fire-Homeowners
403	Fire-Homeowners Multiple Peril
404	Fire-Farm Owners Multiple Peril
414	Residential Earthquake
450	Inland Marine
500	General Liability
501	Gen. Liability-Pollution Legal Liability
502	General Liability-Product Tampering

### CODE TYPE OF INSURANCE

510	Aviation
550	Errors & Omissions-All Others
551	Errors & Omission-Directors & Officers
600	Malpractice-All Other
606	Malpractice-Hospitals
650	Miscellaneous
651	Miscellaneous-Glass
652	Miscellaneous-Boiler & Machinery
653	Miscellaneous-Nuclear Risks
655	Miscellaneous-Political Risks
700	Accident
701	Accident-Disability Income
702	Accident-Group Health Ins.
703	Accident-Ind. Health Ins.
800	Garage Liability
980	Excess Workers Compensation
990	Commercial Property-All Risk
994	Commercial Property-Special Multi-Peril
996	Commercial Property-DIC
997	Commercial Property-Earthquake
998	Commercial Property-Terrorism
999	Commercial Property-Special Multi-Peril w/Terrorism

(This list does not include those coverages on the export list. An updated export coverage list is published every year by the California Dept. of Insurance.)



AGENCY CUSTOMER ID:

**INSURANCE SUPPLEMENT**

AGENCY		APPLICANT/NAMED INSURED	
POLICY NUMBER		CARRIER	NAIC CODE

**POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE**

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, that you have a right to purchase insurance coverage for losses resulting from acts of terrorism, as defined in Section 102(1) of the Act: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury - in concurrence with the Secretary of State, and the Attorney General of the United States - to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A \$100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR COVERAGE MAY BE REDUCED.

**Acceptance or Rejection of Terrorism Insurance Coverage**

- I hereby elect to purchase terrorism coverage for a prospective premium of \$\_\_\_\_\_.
- I hereby decline to purchase terrorism coverage for certified acts of terrorism. I understand that I will have no coverage for losses resulting from certified acts of terrorism.

_____ Policyholder/Applicant's Signature	_____ Print Name	_____ Date
_____ Policyholder/Applicant's Signature	_____ Print Name	_____ Date
_____ Policyholder/Applicant's Signature	_____ Print Name	_____ Date

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## Loss Warranty Letter

During the last three (3) years, we warrant that with respect to the insurance being applied for:

1. I/We have not sustained a loss,
2. Have not had a claim made against us,
3. have not been denied coverage or had coverage canceled by an insurance company,
4. have no knowledge or a reason to anticipate a claims or loss.

If my business is less than three (3) years old, the above referenced warranty applies to work performed through all my prior business entities whether as an owner or an employee.

I understand that this warranty will be incorporated into the insurance contract.

\_\_\_\_\_  
DBA

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Partner, Officer, Principal or Owner

\_\_\_\_\_  
Title

**Warranty: The purpose of this no loss letter is to assist in the underwriting process information contained herein is specifically relied upon in determination of insurability. The undersigned, therefore, warrants that the information contained herein is true and accurate to the best of his/her knowledge, information and belief. This no loss letter shall be the basis of any insurance that may be issued and will be a part of such policy. It is understood that any misrepresentation or omission shall constitute grounds for immediate cancellation of coverage or rescission of policy and denial of claims, if any. It is further understood that the applicant and or affiliated company is under a continuing obligation to immediately notify his/her underwriter through his/her broker of any material alteration of the information given.**