CLIENT PROPERTY QUESTIONNAIRE
SUPPLEMENTAL APPLICATION

Applicant: ____

(Please list all Insured's)

Address:____

(Number) ***(Street)*** ***(City)*** ***(State)*** ***(Zip Code)***

Effective Date:_______________ **to** _______________ **Prior Coverage:** YES ☐ NO ☐

If yes, Carrier:_____________________ Limits:____________________ Deductible:__________

Requested Limits:____Deductible: ____________________

1. What type of services/work will you perform for your client(s)? Provide details: ________________________________

2. Will this work be performed on your client(s) premises or remotely? Provide details:______________________________

____

3. Will you have access to your client's funds/property (including money, securities, inventory, high value property, banking systems, wire transfer systems, computer systems, sensitive computer data, etc)? ☐ NO ☐ YES If YES, advise to what extent you will have access to this property along with the approximate dollar value:

____

4. Number of employees who will be performing work for your client(s)? __________________________________

5. To what extent do you perform background checks on your employees?

☐ Prior employment ☐ Reference checks ☐ Criminal records ☐ Credit history ☐ Drug testing

6. Will you be performing services for your client(s) during normal business hours? ☐ YES ☐ NO

If NO, at what time will you be performing your work?_____________________ ____________________________

7. Will your employees be supervised by your client(s) while performing services? ☐ YES ☐ NO

If NO, what safeguards will be in place? ____

____

8. What physical and internal controls are in place to prevent and detect Employee Theft losses involving your client's

Funds and /or property? Provide details:____

____

9. To what extent will your client(s) audit the services you provide for them? Provide details: ________________________

____

10. Do you have any knowledge of an employee stealing from a client in the past or at this time? ☐ YES ☐ NO If YES, provide complete details including correctives implemented.____

____

12. Provide a list of the client(s) that you will be providing services for. If services are being provided under a contract, indicate the start and completion date and attach a copy of the contract(s).

NAME OF CLIENT	LIMIT OF COVERAGE REQUESTED	START & END DATE OF CONTRACT	DOLLAR AMOUNT OF CONTRACT
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$

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 bond or policy issued in reliance upon such information.

Dated at ______________________ **this** ________ **day of** ______________ **20** ________

______________________________ **By:** ______________________________________
(Print Insured Name) (Signature)

____
(Name and Title of Person Signing)

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