

AMERICAN ASSOCIATION OF RADON SCIENTISTS AND TECHNOLOGISTS APPLICATION

PLEASE ANSWER ALL QUESTIONS COMPLETELY

INSTRUCTIONS: This application is to be used when applying for coverage within the AARST program. Please complete all applicable sections of this application. Read all questions carefully and provide complete and accurate answers. Failure to provide complete or accurate information may result in delayed consideration of this application or denial of coverage. This application is not an insurance policy and the Company considering coverage reserves the right to reject any application for any reason. If additional space is needed, please attach details to this application on a separate piece of paper. All applicants must sign and date the application where indicated.

NOTICE: For certain policies and coverage parts issued, the limits of liability available to pay judgments for settlements shall be reduced by amounts incurred for legal defense. Further note that amounts incurred for legal defense shall be applied against the deductible or self-insured retention amount.

| I. APPLICANT INFORMATION | | | |
|--|--------|------|----------|
| APPLICANT NAME: | | | DATE: |
| ADDRESS: | | | PHONE: |
| CITY: | STATE: | ZIP: | EMAIL: |
| AARST CERTIFICATION MEMBER NUMBER: | | | WEBSITE: |
| ENTITY IS: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other (Please Explain): | | | |

| II. REQUESTED COVERAGE | |
|--|-------------------------------|
| <input type="checkbox"/> Commercial General Liability <input type="checkbox"/> Contractor's Pollution Liability <input type="checkbox"/> Errors & Omissions Liability <input type="checkbox"/> Following Form Excess | |
| Requested Effective Date: | Existing Retroactive Date(s): |
| Requested Limits of Insurance: | Requested Deductible: |

| III. EXPIRING INSURANCE | | | |
|-----------------------------------|------------------------------|----------------------------------|------------------------------|
| | Commercial General Liability | Contractor's Pollution Liability | Errors & Omissions Liability |
| Carrier: | | | |
| Expiration Date: | | | |
| Limits of Insurance: | | | |
| Deductible: | | | |
| Retroactive Date (if applicable): | | | |
| Premium: | | | |

| IV. EXPOSURES | |
|--|--|
| Total Revenue for most recent 12-month fiscal period: | |
| Anticipated Revenue for next 12-month fiscal period: | |
| Total number of Employees (including officers/partners): | |
| Describe any operations or services performed outside of the U.S.: | |

| V. CONTRACTED SERVICES | | |
|--|--------------------|-----------------|
| | Associated Revenue | % Subcontracted |
| Radon Mitigation System Design | | |
| Radon Mitigation System Installation | | |
| Radon Testing | | |
| General Contracting (<i>not associated with radon</i>) | | |
| Other (<i>please explain</i>) | | |
| Other (<i>please explain</i>) | | |

| VI. OPERATING PRACTICES | |
|--|--|
| Does the applicant use a standard written contract with all clients? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Are all sub-contractors and sub-consultants hired under a written standard contract? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Are all sub-contractors and sub-consultants required to carry Commercial General Liability coverage? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

| VII. CLAIM INFORMATION | |
|--|--|
| Has any claim, suit or notice of incident been made against the applicant or any staff member? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <i>If "YES", please provide complete details for each applicable claim, suit or incident (attach additional pages as necessary):</i> | |
| Is the applicant aware of any claims, suits, incidents or occurrences against the applicant, the applicant's predecessors, any past or present partner of officers, or any staff which have not been reported and that could give rise to a claim? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <i>If "YES", please provide complete details for each applicable claim, suit or incident (attach additional pages as necessary):</i> | |

FRAUD WARNING: APPLICABLE TO ALL STATES

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to criminal and civil penalties.

WARRANTY STATEMENT

The signatory declares that (s)he is authorized by the Applicant to sign this application on behalf of all prospective **insureds** and that, to the best of his/her knowledge, the statements herein are true and accurate. The signatory agrees that if the information supplied in this application and the materials submitted therewith should change between the date this application is signed and the effective date of the proposed insurance, the signatory shall immediately notify the **insurer** of such and shall provide the **insurer** with information that would complete, update or correct the application and materials submitted therewith. The **insurer** may withdraw or modify any of the terms or conditions of coverage accordingly.

| | |
|----------------------|---------------|
| Signature: | Date: |
| Printed Name: | Title: |

**POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE**

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, 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 or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, 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% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020] 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. |

Named Insured

Policyholder/Applicant's Signature

Insurance Company

Print Name

Policy Number

Date

NOTE: Excepting Hawaii domiciled insureds, if you do not complete and return this form or advise us otherwise in writing of your terrorism election then, a rejection of terrorism coverage will be deemed to have been made. If you are domiciled in Hawaii, your failure to complete and return this form is deemed an acceptance of our terrorism offer.