



AGENCY CUSTOMER ID: \_\_\_\_\_

**UMBRELLA / EXCESS SECTION**

DATE (MM/DD/YYYY)

**08/11/25**

**IMPORTANT - If CLAIMS MADE is checked in the POLICY INFORMATION section below, this is an application for a claims-made policy.**  
**Read all provisions of the policy carefully.**

AGENCY <b>ROYAL STAR INSURANCE BROKERAGE CORP</b>		CARRIER <b>Berkley Insurance Company</b>	NAIC CODE <b>32603</b>
POLICY NUMBER <b>FEI-ECC-36380-00</b>	EFFECTIVE DATE <b>03/25/25</b>	NAMED INSURED(S) <b>A.C.T. ABATEMENT CORPORATION</b>	

**POLICY INFORMATION**

TRANSACTION TYPE				LIMIT OF LIABILITY		RETAINED LIMIT
<input checked="" type="checkbox"/> NEW	<input type="checkbox"/> UMBRELLA	<input checked="" type="checkbox"/> OCCURRENCE	<input type="checkbox"/> VOLUNTARY	\$ <b>5,000,000</b> EA OCC		\$
<input type="checkbox"/> RENEWAL	<input checked="" type="checkbox"/> EXCESS	<input type="checkbox"/> CLAIMS MADE		\$ <b>5,000,000</b> AGG		FIRST DOLLAR DEFENSE (Y / N) <input checked="" type="checkbox"/> N
EXPIRING POL #:						

**EMPLOYEE BENEFITS LIABILITY**

LIMIT OF INSURANCE (Ea Employee) \$	AGGREGATE LIMIT FOR EBL \$	RETAINED LIMIT FOR EBL \$	RETROACTIVE DATE FOR EBL
NAME OF BENEFIT PROGRAM			

**PRIMARY LOCATION & SUBSIDIARIES (ACORD 125)**

#	NAME AND LOCATION OF PRIMARY AND ALL SUBSIDIARY COMPANIES (Describe Operations)	ANNUAL PAYROLL	ANN GROSS SALES	FOREIGN GROSS SALES	# EMPL
	NAME: <b>SAME AS ACORD 125</b> LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				
	NAME: LOCATION: DESCRIPTION:				

**UNDERLYING INSURANCE**

LIST ALL LIABILITY / COMPENSATION POLICIES IN FORCE TO APPLY AS UNDERLYING INSURANCE

TYPE	CARRIER / POLICY NUMBER	POLICY EFF DATE	POLICY EXP DATE	LIMITS	ANNUAL RENEWAL PREMIUM	+- RATING MOD
AUTOMOBILE LIABILITY				CSL EA ACC \$	\$	
				BI EA ACC \$	\$	
				BI EA PER \$	\$	
				PD EA ACC \$	\$	
GENERAL LIABILITY POLICY TYPE <input type="checkbox"/> OCCUR <input checked="" type="checkbox"/> CLAIMS MADE	<b>BERKLEY FEI-ECC-36380-00</b>	<b>03/25/25</b>	<b>01/16/26</b>	EACH OCCURRENCE \$ <b>1,000,000</b>	PREM / OPS	
				GENERAL AGGR \$ <b>2,000,000</b>	\$	
				PROD & COMP OPS AGGREGATE \$ <b>2,000,000</b>	PRODUCTS	
				PERSONAL & ADV INJURY \$ <b>1,000,000</b>	\$	
				DAMAGE TO RENTED PREMISES \$ <b>50,000</b>	OTHER	
				MEDICAL EXPENSE \$ <b>5,000</b>	\$	
EMPLOYERS LIABILITY				EACH ACCIDENT \$	\$	
				DISEASE EACH EMPLOYEE \$		
				DISEASE POLICY LIMIT \$		
1ST EXCESS	<b>BERKLEY INS CO FEI-EXS-45860-00</b>	<b>03/25/25</b>	<b>01/16/26</b>	EACH OCC/GEN AGG <b>5,000,000</b>	\$	
					\$	

# UNDERLYING INSURANCE (continued)

AGENCY CUSTOMER ID: \_\_\_\_\_

## UNDERLYING GENERAL LIABILITY INFORMATION (Explain all "YES" responses)

1. ARE DEFENSE COSTS: ☐ WITHIN AGGREGATE LIMITS? ☐ A SEPARATE LIMIT? ☐ UNLIMITED?  
(In Arkansas, the underlying General Liability coverage cannot contain defense costs within aggregate limits, but must have a separate, equal limit or must be unlimited.)  
(In Oklahoma, the underlying General Liability coverage cannot contain defense costs within the limits; subject to Commissioner's Orders.)

2. INDICATE THE EDITION DATE OF THE ISO FORM OR SIMILAR FILING FOR THE UNDERLYING COVERAGE:

3. HAS ANY PRODUCT, WORK, ACCIDENT OR LOCATION BEEN EXCLUDED, UNINSURED OR SELF-INSURED FROM ANY PREVIOUS COVERAGE? (Y / N) ☒ N

4. FOR CLAIMS MADE, INDICATE RETROACTIVE DATE OF CURRENT UNDERLYING POLICY:

5. FOR CLAIMS MADE, INDICATE ENTRY DATE INTO UNINTERRUPTED CLAIMS MADE COVERAGE:

6. FOR CLAIMS MADE, WAS "TAIL" COVERAGE PURCHASED FOR ANY PREVIOUS PRIMARY OR EXCESS POLICY? (Y / N) ☒ N EFF. DATE: \_\_\_\_\_

CHECK ALL COVERAGES IN UNDERLYING POLICIES. ALSO CHECK IF ANY EXPOSURES ARE PRESENT FOR EACH COVERAGE. PROVIDE AN EXPLANATION. EXPLAIN IF DIFFERENT LIMITS, EXTENSIONS, OR EXCLUSIONS. EXPLAIN ANY SPECIAL COVERAGES BEYOND STANDARD FORMS. **EXPLAIN ALL EXPOSURES.**

CHECK IF APPROPRIATE		COVERAGE		EXPOSURE	COVERAGE		EXPOSURE
<input type="checkbox"/>	ANY AUTO (SYMBOL 1)	<input type="checkbox"/>	CARE, CUSTODY, CONTROL	<input type="checkbox"/>	<input type="checkbox"/>	PROFESSIONAL LIABILITY (E&O)	<input type="checkbox"/>
<input type="checkbox"/>	CGL - CLAIMS MADE	<input type="checkbox"/>	EMPLOYEE BENEFIT LIABILITY	<input type="checkbox"/>	<input type="checkbox"/>	VENDORS LIABILITY	<input type="checkbox"/>
<input type="checkbox"/>	CGL - OCCURRENCE	<input type="checkbox"/>	FOREIGN LIABILITY / TRAVEL	<input type="checkbox"/>	<input type="checkbox"/>	WATERCRAFT LIABILITY	<input type="checkbox"/>
COVERAGE		EXPOSURE	<input type="checkbox"/>		<input type="checkbox"/>		
<input type="checkbox"/>	AIRCRAFT LIABILITY	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
<input type="checkbox"/>	AIRCRAFT PASSENGER LIABILITY	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
<input type="checkbox"/>	ADDITIONAL INTERESTS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		

UNDERLYING INSURANCE COVERAGE INFORMATION (INCLUDE ALL RESTRICTIONS; e.g. LASER ENDORSEMENTS, DISCRIMINATION, SUBROGATION WAIVERS, OR EXTENSIONS OF COVERAGE) ACORD 101, Additional Remarks Schedule, may be attached if more space is required.

PREVIOUS EXPERIENCE: (GIVE DETAILS OF ALL LIABILITY CLAIMS EXCEEDING \$10,000 OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS, DURING THE PAST FIVE (5) YEARS, WHETHER INSURED OR NOT. SPECIFY DATE, COVERAGE, DESCRIPTION, AMOUNT PAID, AMOUNT OUTSTANDING) ACORD 101, Additional Remarks Schedule, may be attached if more space is required.

☐ NO SUCH CLAIMS

## CARE, CUSTODY, CONTROL

LOC	PROPERTY TYPE	VALUE	A*	B*	C*	D*	SQ FT OF BLDG OCC
<input type="checkbox"/>	REAL		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	PERSONAL		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

## OCCUPANCY / DESCRIPTION OF PERSONAL PROPERTY

\*APPLICANT: [A] IS HELD HARMLESS IN THE LEASE, [B] HAS A WAIVER OF SUBROGATION, [C] IS A NAMED INSURED IN THE FIRE POLICY, [D] OTHER (specify)

## VEHICLES

TYPE	# OWNED	# NON-OWNED	# LEASED	PROPERTY HAULED	RADIUS (MILES)		
					LOCAL	INTER-MEDIATE	LONG DISTANCE
PRIVATE PASSENGER							
TRUCKS	LIGHT						
	MEDIUM						
	HEAVY						
	EX. HEAVY						
TRUCKS / TRACTORS	HEAVY						
	EX. HEAVY						
BUSES							

**ADDITIONAL EXPOSURES**

AGENCY CUSTOMER ID: \_\_\_\_\_

EXPLAIN ALL "YES" RESPONSES, PROVIDE OTHER INFORMATION REQUIRED										Y / N
<b>ADVERTISERS LIABILITY</b>										
1. MEDIA USED: ANNUAL COST: \$										
2. ARE SERVICES OF AN ADVERTISING AGENCY USED?										N
3. ANY COVERAGE PROVIDED UNDER AGENCY'S POLICY?										N
<b>AIRCRAFT LIABILITY</b>										
4. DOES APPLICANT OWN / LEASE / OPERATE AIRCRAFT?										N
<b>AUTO LIABILITY</b>										
5. ARE EXPLOSIVES, CAUSTICS, FLAMMABLES OR OTHER DANGEROUS CARGO HAULED?										N
6. ARE PASSENGERS CARRIED FOR A FEE?										N
7. ANY UNITS NOT INSURED BY UNDERLYING POLICIES?										N
8. ARE ANY VEHICLES LEASED OR RENTED TO OTHERS?										N
9. ARE HIRED AND NON-OWNED COVERAGES PROVIDED?										N
<b>CONTRACTORS LIABILITY</b>										
10. IS BRIDGE, DAM, OR MARINE WORK PERFORMED?										N
11. DESCRIBE TYPICAL JOBS PERFORMED (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)										
12. DESCRIBE AGREEMENT (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)										
13. DOES APPLICANT OWN, RENT, OR OTHERWISE USE CRANES?										N
14. DO SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN APPLICANT?										N
<b>EMPLOYERS LIABILITY</b>										
15. IS APPLICANT SELF-INSURED IN ANY STATE?										N
16. SUBJECT TO:		JONES ACT		FELA		STOP GAP		OTHER:		
<b>INCIDENTAL MALPRACTICE LIABILITY</b>										
17. IS A HOSPITAL OR FIRST AID FACILITY MAINTAINED?										N
18. ARE COVERAGES PROVIDED FOR DOCTORS / NURSES?										N
19. INDICATE # OF DOCTORS:                      NURSES:                      BEDS:										

**AGENCY CUSTOMER ID:** \_\_\_\_\_

**REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)**

## FRAUD STATEMENTS

**Applicable in AL, AR, DC, LA, MD, NM, RI and WV:** Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. \*Applies in MD Only.

**Applicable in CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Applicable in FL and OK:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)\*. \*Applies in FL Only.

**Applicable in KS:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA:** 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 subjects such person to criminal and civil penalties\* (not to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY Only.

**Applicable in ME, TN, VA and WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME Only.

**Applicable in NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Applicable in OR:** Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**Applicable in PR:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**SIGNATURE**

IF THE COMPANY TO WHICH I AM APPLYING OFFERS UNINSURED MOTORISTS (UM), UNDERINSURED MOTORISTS (UIM) AND/OR MEDICAL PAYMENTS COVERAGE IN MY STATE:

UNINSURED MOTORISTS (UM) COVERAGE: \$ \_\_\_\_\_ \*

UNDERINSURED MOTORISTS (UIM) COVERAGE: \$ \_\_\_\_\_ \*

MEDICAL PAYMENTS COVERAGE: \$ \_\_\_\_\_ \* IF APPLICABLE IN YOUR STATE

**APPLICABLE ONLY IN LOUISIANA, MONTANA, NEW HAMPSHIRE AND VERMONT**

**APPLICABLE ONLY IN LOUISIANA:**

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS, UM LIMITS LOWER THAN MY LIABILITY LIMITS, OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION.  OR  
(INITIALS)

2. I REJECT UM COVERAGE IN ITS ENTIRETY.   
(INITIALS)

**APPLICABLE ONLY IN MONTANA:**

I ACKNOWLEDGE I HAVE BEEN OFFERED UNINSURED MOTORISTS (UM) COVERAGE AND UNDERINSURED MOTORISTS (UIM) COVERAGE. I HAVE SELECTED THE LIMITS INDICATED IN THIS APPLICATION. IF NO LIMITS ARE SHOWN, I HAVE REJECTED THESE COVERAGES.  (INITIALS)

**APPLICABLE ONLY IN NEW HAMPSHIRE:**

I ACKNOWLEDGE THAT UM COVERAGE HAS BEEN EXPLAINED TO ME, AND I HAVE BEEN OFFERED THE OPTION OF SELECTING UM LIMITS EQUAL TO MY LIABILITY LIMITS OR TO REJECT UM COVERAGE ENTIRELY.

1. I SELECT UM LIMITS INDICATED IN THIS APPLICATION.  OR  
(INITIALS)

2. I REJECT UM COVERAGE IN ITS ENTIRETY.   
(INITIALS)

**APPLICABLE ONLY IN VERMONT:**

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED UM COVERAGE EQUAL TO MY LIABILITY LIMITS. I HAVE SELECTED THE LIMITS INDICATED IN THIS APPLICATION.

IMPORTANT - THE STATEMENTS (ANSWERS) GIVEN ABOVE ARE TRUE AND ACCURATE. THE APPLICANT HAS NOT WILLFULLY CONCEALED OR MISREPRESENTED ANY MATERIAL FACT OR CIRCUMSTANCE CONCERNING THIS APPLICATION. THIS APPLICATION DOES NOT CONSTITUTE A BINDER.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER