

HAWAII

Janitorial Services

Bond Application

APPLICANT INFORMATION

APPLICANTS NAME: (AS IT IS TO APPEAR ON BOND)

BUSINESS ADDRESS: (STREET, CITY, STATE, ZIP)

BUSINESS PHONE:

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SOCIAL SECURITY OR TAXPAYER ID#:

PLEASE DESCRIBE THE NATURE OF YOUR OPERATIONS:

DATE STARTED:

- PROPRIETORSHIP PARTNERSHIP
 CORPORATION LLC

WHAT PERCENTAGE OF YOUR CUSTOMERS ARE: COMMERCIAL _____% RESIDENTIAL _____%

WHAT PERCENTAGE OF YOUR REVENUE IS: COMMERCIAL _____% RESIDENTIAL _____%

IS THIS BOND REQUIRED TO MEET THE TERMS OF A CONTRACT? YES NO IF YES, PLEASE COMPLETE THE INFORMATION BELOW AND PROVIDE A COPY OF THE CONTRACT WITH THIS APPLICATION.

NAME OF COMPANY CONTRACTED WITH: _____

AMOUNT OF CONTRACT: \$ _____ CONTRACT TERM: _____ YEARS _____ MONTHS

BOND INFORMATION

BOND AMOUNT:

EFFECTIVE DATE:

PREVIOUSLY BONDED BY:

PREVIOUS BOND #:

HAVE YOU SUSTAINED ANY EMPLOYEE DISHONESTY LOSSES IN THE LAST SIX (6) YEARS? YES NO IF YES, GIVE A DETAILED EXPLANATION.

NUMBER OF OWNERS:

NUMBER OF EMPLOYEES:

READ CAREFULLY AND SIGN

I/WE THE UNDERSIGNED, DECLARE THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT. **ADDITIONALLY I/WE ACKNOWLEDGE THAT THE FIRST YEAR'S PREMIUM IS FULLY EARNED UPON ISSUANCE OF THE REQUESTED BOND** AND I/WE AGREE TO PAY ALL PREMIUMS AS THEY BECOME DUE. I/WE ALSO ACKNOWLEDGE AND UNDERSTAND THAT THIS BOND WILL ONLY COVER ACTS OF EMPLOYEES FOR WHICH SAID EMPLOYEE IS CONVICTED OF CRIMINAL ACTS BY A COURT OF PROPER JURISDICTION. I/WE UNDERSTAND THAT EACH LOSS PAID BY THE SURETY IS SUBJECT TO A DEDUCTIBLE IN THE AMOUNT OF \$100.00 FOR EACH EMPLOYEE COMMITTING AN ACT WHICH CAUSES A LOSS.

SIGNED THIS _____ DAY OF _____, _____.

PLEASE NOTE: ALL OWNERS MUST SIGN BELOW (use additional pages if necessary).

PRINT NAME AND TITLE:

SIGNATURE:

X

SOCIAL SECURITY #:

PRINT NAME AND TITLE:

SIGNATURE:

X

SOCIAL SECURITY #:

PRINT NAME AND TITLE:

SIGNATURE:

X

SOCIAL SECURITY #:

PRINT NAME AND TITLE:

SIGNATURE:

X

SOCIAL SECURITY #:

PRODUCER # OR NAME:

SURETY:

BOND#:

PREMIUM SCHEDULE

Rates For Five (5) Employees or Less

(Minimum earned premium is \$100.00)

Amount of Coverage	One (1) Year Premium
\$ 2,500	\$ 100
\$ 5,000	\$ 100
\$ 10,000	\$ 100
\$ 25,000	\$ 250
\$ 30,000	\$ 300
\$ 40,000	\$ 400
\$ 50,000	\$ 500
\$ 60,000	\$ 600
\$ 75,000	\$ 750
\$ 80,000	\$ 800
\$ 90,000	\$ 900
\$ 100,000	\$ 1,000

Submit requests to your local representative for rate quote if Applicant has more than 100 employees or is requesting limits in excess of \$20,000.

Add \$3.50 for each additional employee over 5 and up to 100 (including owners).