

**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 the Individual)

- (A) Duly licensed under 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)

(C) **Description of Risk** \_\_\_\_\_  
(City) (State) (Zip Code)

(D) **Location of Risk** \_\_\_\_\_  
(e.g. Laundromat, liquor store, NOT TYPE OF COVERAGE)

(E) **Location of Risk** \_\_\_\_\_  
(Street and Number)

(F) **Location of Risk** \_\_\_\_\_  
(City) (State) (Zip Code)

(G) **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)

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

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 \_\_\_\_\_

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: \_\_\_\_\_

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 & Last Name of Company Representative AND Telephone Number	Check if Employee (E) or Agent (A)	Month, Year of Declination	Declination Code*
1.		E (	/	
	( ) - or "Online Declination" Website	A		
2.		E (	/	
	( ) - or "Online Declination" Website	A		
3.		E (	/	
	( ) - or "Online Declination" Website	A		

\*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.

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

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

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

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)