MISSISSIPPI DEPARTMENT OF INSURANCE
ELIGIBLE NONADMITTED INSURANCE FORM

Miss. Code Ann.§ 83-21-19 provides that certain insurance coverages that cannot be procured from admitted insurers may be procured from eligible nonadmitted insurers. Any licensed Mississippi surplus lines insurance producer procuring coverage from an eligible nonadmitted insurer must complete this form acknowledging that the coverage has been placed with an eligible nonadmitted insurer. After completion, this form must be retained by the surplus lines insurance producer as part of the insured's file, and may be subject to review by the Commissioner of Insurance at any time if the Commissioner deems such request advisable.

A licensed Mississippi surplus lines insurance producer is required to engage in a diligent effort to place the coverage with an admitted insurer. The signature of the producer appearing below shall serve as an attestation to the results of the diligent effort on the part of the producer. The licensed Mississippi surplus lines insurance producer is also required to expressly advise the insured that, in the event of the insolvency of the nonadmitted insurer, CLAIMS OR LOSSES WILL NOT BE PAID BY THE MISSISSIPPI INSURANCE GUARANTY ASSOCIATION.

LICENSED MISSISSIPPI SURPLUS LINES INSURANCE PRODUCER CERTIFICATION

As required by Miss. Code Ann.§ 83-21-23, the surplus lines insurance producer signing below certifies that he or she engaged in a diligent effort to place the risk with an admitted company or companies. Please state in detail the reason for placing the coverage with an eligible nonadmitted insurer or insurers:

The agent's search of admitted markets within the state did not yield adequate coverages or pricing as desired by the consumer.

_____

_____

Name of Eligible Nonadmitted Insurer(s) from which the coverage was procured:

_____

!Nonadmitted Insurer's Name(s)]

Mississippi Surplus Lines Insurance Producer's Name:

Surplus Lines Insurance Producer's Mississippi License Number:

Insured's Name:

Policy or Binder Number:

Signature _____

(Surplus Lines Insurance Producer) **Date:** **Phone:**

SSIU SOUTH SHORE INSURANCE UNDERWRITERS

APPLICATION ACKNOWLEDGEMENTS

NO FLOOD COVERAGE

I understand my policy **does NOT** include any coverage for damage caused by Flood unless specifically stated on the applications and declarations page. Flood means surface water, waves, tidal water, tidal surge, overflow of a body of water, or spray from any of these, whether or not driven by wind. By placing your initials at the end of this paragraph and signing this Notice below, you confirm that you understand, acknowledge and accept that this provision is included in the policy for which you have applied and any other new or renewal policies issued to you by SSIU.

CLIENTS INITIALS: _____

STORM SHUTTER/IMPACT GLASS & ALARM CREDIT

If I install, or have previously installed, qualified storm shutters, or a monitored premise burglar and fire alarm/protection device on the "premise for which this insurance is being applied," I agree to maintain these protection devices, for which I have been granted a credit, in good working order and commit to utilize them. I also agree to notify SSIU immediately of any change, including removal, made to the system(s). Failure to notify SSIU of such change could result in the voidance of the insurance agreement. By placing your initials at the end of this paragraph and signing this Notice below, you confirm that you understand, acknowledge and accept that this provision is included in the policy for which you have applied and any other new or renewal policies issued to you by SSIU. **I understand that the storm shutters or impact glass should protect all glazed surfaces on the building**

CLIENTS INITIALS: _____

VALUATION DISCLAIMER

I understand that the valuation of my property and belongings is my own responsibility and NOT the responsibility of SSIU or the companies it represents. I agree to release SSIU and any of its subsidiaries, agents, employees and the companies they represent from any responsibility with regards to the valuation and insured amount of my property and belongings. I also understand that my policy contains a coinsurance clause which could reduce the insurance coverage available to me in the event of a loss. By placing your initials at the end of this paragraph and signing this Notice below, you confirm that you understand, acknowledge and accept that this provision is included in the policy for which you have applied and any other new or renewal policies issued to you by SSIU.

CLIENTS INITIALS: _____

DEDUCTIBLE DISCLAIMER

I understand that my policy has deductibles, which could result in large out of pocket expense to me. By placing your initials at the end of this paragraph and signing this Notice below, you confirm that you understand, acknowledge and accept that this provision is included in the policy for which you have applied and any other new or renewal policies issued to you by SSIU.

CLIENTS INITIALS: _____

CANCELLATION

I understand that the policy being provided to me by SSIU contains a Minimum Earned Premium provision, which states that in the event of a cancellation, SSIU is entitled to and will retain the Minimum Earned Premium percentage specified in my policy. In addition, I understand that all fees charged at the time of policy issuance are non-refundable. Furthermore, I acknowledge that the policy being provided includes a Short Rate Return provision. By placing your initials at the end of this paragraph and signing this Notice below, you confirm that you understand, acknowledge and accept that this provision is included in the policy for which you have applied and any other new or renewal policies issued to you by SSIU.

CLIENTS INITIALS: _____

PAYMENT

I understand that payment for my policy is due to SSIU within ten (10) days of the effective date of my policy, or the policy will be cancelled automatically for non-payment. I acknowledge that it is my responsibility to remit payment to my Agent of Record in a timely manner so that payment may be forwarded to SSIU within the above-stipulated time frame. By placing your initials at the end of this paragraph and signing this Notice below, you confirm that you understand, acknowledge and accept that this provision is included in the policy for which you have applied and any other new or renewal policies issued to you by SSIU.

CLIENTS INITIALS: _____

INSPECTIONS

I understand that a third party inspection service provider will contact me. I agree that I will make every effort possible to schedule an inspection appointment in a timely manner and understand that my policy may be cancelled if an inspection has not been performed within thirty days of the effective date, unless prior arrangements have been conveyed and agreed upon.

CLIENTS INITIALS: _____

PHONE 1: _____ **PHONE 2:** _____ **EMAIL:** _____

CLIENT SIGNATURE: _____ **DATE:** _____

POLICYHOLDER DISCLOSURE

NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, as defined in Section 102(1) of the Act, as amended: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, 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 an air carrier or vessel 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. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2014, the date on which the TRIA Program is scheduled to terminate or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES 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 THIS FORMULA, THE UNITED STATES PAYS 85% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. 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.

THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

☐	I hereby elect to purchase coverage for acts of terrorism for a prospective premium of $_____, state surplus lines tax of $_____, total terrorism premium of $_____.
☐	I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

_____ _____

Policyholder / Applicant Signature Company

_____ _____

Print Name Policy Number

_____

Date

STATEMENT OF DILIGENT EFFORT

Producing Agent _____ License Number _____

Name of Agency _____

Has sought to obtain:

Type of Coverage _____ for

Named Insured _____ from the following

authorized insurers currently writing this type of coverage:

(1) Authorized Insurer _____ Person Contacted _____

Telephone Number _____ Date of Contact _____

The reason(s) for declination by the insurer was (were) as follows:

_____

(2) Authorized Insurer _____ Person Contacted _____

Telephone Number _____ Date of Contact _____

The reason(s) for declination by the insurer was (were) as follows:

_____

(3) Authorized Insurer _____ Person Contacted _____

Telephone Number _____ Date of Contact _____

The reason(s) for declination by the insurer was (were) as follows:

_____

_____

Signature of Producing Agent Printed or Typed Name of Producing Agent

Document Verified by Surplus Lines Agent Yes X No ____ Date Verified: _____