

SURETY BOND VERIFICATION

Reply to: California Department of Public Health
Licensing and Certification Program
Centralized Applications Unit
P.O. Box 997377, MS 3402
Sacramento, CA 95899-7377

California Health and Safety Code, Section 1318, Chapter 2, Division 2, requires that licensed health facilities that handle money in excess of \$25 per patient or over \$500 for all patients in any month, be bonded for not less than \$1,000. This is to serve as a guarantee for the faithful and honest handling of the money of such patients.

INSTRUCTIONS: This form is to be completed by the bonding agency. In addition, attach an *original copy of the bond*. In the event of cancellation of the bond, please send notice to the above licensing office.

BE IT KNOWN THAT:

Facility name _____

Facility address _____ City _____ County _____ ZIP code _____

State of California, as *Principal*, and

Bonding agency _____

Agency address _____ City _____ County _____ ZIP code _____

State of _____, as *Surety*, are held and firmly bound unto the STATE OF CALIFORNIA in the full and just sum of

_____ DOLLARS (\$ _____), for the payment of which the said Principal and said Surety bind themselves, their respective heirs, successors, and assigns, jointly and severally, firmly by these presents.

The **CONDITION** of this obligation is such that

WHEREAS, the Principal has applied for or has been issued a license by the California Department of Public Health to maintain or conduct a health facility pursuant to Chapter 2, Division 2, of the Health and Safety Code of the State of California; and

WHEREAS, by the terms of Section 1318 of said code, the Principal is required to file with the California Department of Public Health, Licensing and Certification, the bond running to the State of California.

NOW, THEREFORE, if the above bounden Principal shall faithfully and honestly handle money of patients in the care of said Principal, then this obligation shall be null and void; otherwise to remain in full force and effect.

Every patient injured as a result of any improper or unlawful handling of the money of a patient of a health facility may bring an action in a proper court on the bond required to be posted by the licensee pursuant to this section for the amount of damage he/she suffered as a result thereof to the extent covered by the bond.

This bond may be canceled by the Surety in accordance with the provisions of Section 996.310 et seq. of the Code of Civil Procedure. This bond is effective _____ and continuous.

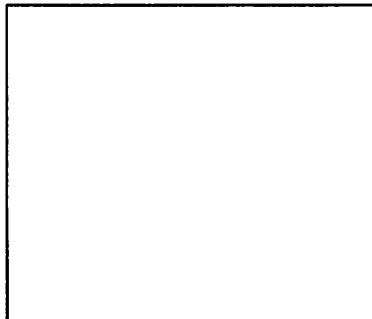
Date

IN WITNESS WHEREOF, we have subscribed our names and impressed our seal this _____ Day _____ Month _____ Year _____

Bonding agent name (please print)

Bonding agent signature

BONDING AGENCY SEAL



Surety Bond Application

AGENCY NAME: _____ AGENCY CONTACT: _____
AGENCY PHONE: _____ AGENCY FAX: _____ AGENCY EMAIL: _____
AGENCY ADDRESS: _____ City: _____ State: _____ Zip: _____

CURRENT OR EXPIRING QUOTE WE ARE LOOKING TO BEAT? _____

NAME OF PREVIOUS SURETY COMPANY WRITING THE BOND? _____

SECTION I: BOND APPLIED FOR

Type of Bond: _____ Effective Date: _____ Expiration Date: _____

Type of Company **CORP** ☐ **LLC** ☐ **DBA** ☐ **PARTNERSHIP** ☐ Bond Amount: _____

(Obligee): _____

Obligee Address _____

SECTION II: GENERAL INFORMATION

Applicant's Name: _____ Spouse Name: _____

SS#: _____ Spouse SS#: _____ Home Phone: () _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Business Name: _____

Business Phone: () _____ Business Fax: () _____ E-mail: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Date Business BEGAN under present Individual or Firm Name: _____ BUSINESS TAX ID: _____

HAS ANY COMPANY REFUSED TO ISSUE BONDS FOR ANY PURPOSE? YES ☐ NO ☐ DO YOU HAVE ANY LIENS, CLAIMS OR JUDGMENTS AGAINST YOU? YES ☐ NO ☐

HAS APPLICANT EVER FAILED IN BUSINESS? YES ☐ NO ☐ HAS APPLICANT EVER FILED BANKRUPTCY? YES ☐ NO ☐

IF YES TO ANY, PLEASE EXPLAIN ON A SEPERATE SHEET OF PAPER

SECTION III: ADDITIONAL OWNERS OR PARTNERS AS REQUIRED

NAME: _____ SPOUSE NAME: _____

SS#: _____ SPOUSE SS#: _____ PHONE: _____

HOME ADDRESS: _____ City: _____ State: _____ Zip: _____

PERSONAL FINANCIALS (IF MORE THAN ONE OWNER, EACH HAS TO FILL OUT THIS APPLICATION)

STATEMENT OF ASSETS AND LIABILITIES AS OF

ASSETS		LIABILITIES	
CASH IN BANK		NOTES PAYABLE TO BANKS	
CASH ON HAND		NOTES TO OTHERS (excl. of equipment)	
STOCKS AND BONDS		ACCOUNTS PAYABLE	
ACCOUNTS RECEIVABLE		FEDERAL & STATE INCOME TAX DUE	
NOTES RECEIVABLE		ALL OTHER TAXES	
INVENTORY		ACCRUALS, PAYROLLS, ETC.	
CASH VALUE LIFE INSURANCE			
EQUIPMENT		DUE ON EQUIPMENT	
REAL ESTATE		DUE ON REAL ESTATE	
OTHER ASSETS		OTHER LIABILITIES	
		CAPITAL STOCK (if a corporation)	
		SURPLUS AND UNDIVIDED PROFITS	
TOTAL ASSETS		TOTAL LIABILITIES	
		NET WORTH	
Name of Owners		Name and Title of Officers	% OWNERSHIP IN COMPANY

COMPLETION OF THIS FORM CONSTITUTES PERMISSION FOR WORLDWIDE INSURANCE SPECIALISTS INC. TO OBTAIN CONSUMER INFORMATION WHICH WILL BE USED TO DETERMINE BONDING ELIGIBILITY. THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE
NO PREMIUM FINANCING WILL BE ACCEPTED AS PREMIUM IS EARNED IN FULL.

Worldwide Insurance Specialists, Inc
2424 W. Missouri AVE
Phoenix, AZ 85015

Toll Free: (888) 518-8011
Local (602) 749-0702
Fax: (602) 674-8235

E-Mail WWIS@WWISINC.COM