



## MISCELLANEOUS PROFESSIONAL LIABILITY INSURANCE APPLICATION

THE APPLICANT IS APPLYING FOR A CLAIMS MADE POLICY, WHICH IF ISSUED, APPLIES ONLY TO CLAIMS FIRST MADE DURING THE POLICY PERIOD. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES, SETTLEMENTS, OR JUDGMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY THE PAYMENT OF CLAIM EXPENSES.

### General instructions for completing this Application:

1. Please read carefully and answer all questions. The information is needed to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to the evaluation.
2. If more space is required to answer a question, attach an additional page and reference the question number for the attachment.
3. The Application **must** be signed by an executive officer.

### APPLICANT INFORMATION:

1. Name of Applicant: \_\_\_\_\_  
(Include names of all subsidiaries or affiliated companies to be insured, attach a separate sheet, if necessary)  
\_\_\_\_\_
2. Business Address: \_\_\_\_\_
3. City, State, Zip: \_\_\_\_\_
4. Phone: \_\_\_\_\_ Fax number: \_\_\_\_\_
5. The Officer designated as agent of the Company and all Insured Persons to receive any and all notices from the Insurer or their authorized representatives concerning this insurance: Title: \_\_\_\_\_  
Name: \_\_\_\_\_ Email: \_\_\_\_\_
6. Applicant Is: Sole Proprietor Partnership Corporation LLC Joint Venture Other: \_\_\_\_\_  
\_\_\_\_\_
7. Date Established: \_\_\_\_\_  
(If less than three (3) years, attach resumes of all principals)
8. WebsiteAddress(es): \_\_\_\_\_  
\_\_\_\_\_
9. Describe in detail the Professional Services for which coverage is desired: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. Is the Applicant engaged in any business or profession other than as described in question 9 above? If **Yes**, please describe: Yes No  
\_\_\_\_\_  
\_\_\_\_\_
11. Is the insurance for which you are applying required by contract? Yes No  
If **yes**, attach a copy of the contract.

12. Is the Applicant controlled or owned by, or associated or affiliated with, or does it own any other firm or business entity: If **Yes**, attach details. Yes No

13. Does Applicant have any subsidiaries or other entities that need to be covered under this policy? If **Yes**, list below: Yes No

Name of Entity	Nature of Operations	% of Ownership	Coverage Desired	
		%	Yes	No
		%	Yes	No
		%	Yes	No

**EXPOSURE INFORMATION:**

1. Please provide the most recent financial information for both the Applicant and any subsidiaries performing professional services to be covered under this policy. If newly established, indicate anticipated gross revenues for current and next projected year.

	Year	Revenues
Current Annualized Fiscal Year:		\$
Most Recent Fiscal Year:		\$
Projected Next Fiscal Year:		\$

2. Complete the following for the Applicant's three (3) largest clients:

Client Name	Professional Services Provided	Annual Revenue Derived
1.		\$
2.		\$
3.		\$

Total number of clients: \_\_\_\_\_

3. Please list the professional services the Applicant provides and the percentage of revenue generated by each service:

Professional Services	% of Revenue
	%
	%
	%

4. During the past Five (5) years has the Applicant changed its name, or been purchased, merged, or consolidated with any other entity? If **Yes**, provide transaction details: Yes No

\_\_\_\_\_

\_\_\_\_\_

5. Is the Applicant a member of any industry / professional associations? If **Yes**, provide details: Yes No

\_\_\_\_\_

\_\_\_\_\_

6. Indicate the total number of persons in each of the following positions:

Principals, Partners, Officers	Professionals	Admin/Clerical	Part-time

7. Provide the following information:

Full Name of ALL Principals, Partners, Officers and Key Professionals	Professional Qualifications	Date Qualified	How Long in Practice	How Long As Partner Principal

8. Does the Applicant use independent contractors or subcontractors? Yes No

If **Yes**:

a. What is the estimated percent of the time they are used? \_\_\_\_\_%

b. Describe the services they perform: \_\_\_\_\_

c. Do you desire coverage for these independent contractors under your policy? Yes No

d. Do you require the independent contractors or subcontractors to carry their own E&O coverage? Yes No

**Attach a sample of the Independent Contractor Agreement**

9. Is management's approval required for all new clients? Yes No

10. Does the Applicant maintain a system to avoid conflicts of interest? Yes No

Describe the Applicant's procedures for resolving disputes with clients over fees or charges:

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11. Does the Applicant require a signed contract for all services? Yes No

If **No**, what percentage of the time does the Applicant require a signed contract? \_\_\_\_\_%

12. Have the Applicant's contracts, engagement and/or proposal letters been reviewed and approved by legal counsel? Yes No

13. Do the Applicant's written contracts or agreements contain:

a. Hold harmless or indemnity agreements to Applicant's favor? Yes No

b. Guarantees or warranties? Yes No

c. A definition of the responsibilities of each party? Yes No

d. Disclaimers or limitations of liability? Yes No

14. In the past 36 months:

a. Have any of the Applicant's clients made allegations or complained about the performance, non-performance, or timeliness of Applicant's products or services? Yes No

b. Have any of the Applicant's clients refused to pay, stopped paying, or requested a refund due to alleged problems with the Applicant's products or services? Yes No

c. Has the Applicant sued any of its clients for nonpayment? If Yes, provide details: Yes No

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**CLAIMS INFORMATION:** (Attach a five (5) year loss history report)

If a **Yes** answer has been given to any of the questions in this section, please provide complete details which should include but not be limited to the following:

1. To the best of the Applicant’s knowledge in the past 36 months, have any of its present Officers, principals, partners, directors, or employees been the subject of any investigation and/or disciplinary action by any government regulatory agency, certifying body, or government entity? Yes No
  
2. To the best of the Applicant’s knowledge in the past 36 months have any of the Applicant’s present directors, officers, principals, owners, partners, salespersons, or employees been convicted of a felony? Yes No
  
3. Is the Applicant aware of any fact, circumstance, situation, error, or omission that can reasonably be expected to result in a claim against the Applicant for the coverage being applied for? Yes No
  
4. Have any claims, suits or proceedings been brought during the past five (5) years against the Applicant or its predecessors in business, affiliates; present directors, officers, principals, owners, partners? Yes No
  
5. Has the Applicant reported the matters listed above to its current or former insurance carrier? Yes No

**CURRENT INSURANCE INFORMATION:**

1. List all Professional Liability insurance carried during the past three (3) years. If none, state “none”.

Insurance Company	Policy Limit	Deductible/Retention	Premium	Policy Period
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	

2. What is the current policy’s retroactive date: \_\_\_\_\_
  
3. Has the Applicant ever had an application for professional liability insurance declined or had a professional liability policy cancelled or nonrenewed by the Insurer? Yes No  
 If **Yes**, describe: \_\_\_\_\_  
 \_\_\_\_\_

The undersigned Applicant represents that the statements set forth in this application and its attachments and other materials submitted to the Insurer are true and correct.

Signing of this application does not bind the Applicant or the Insurer. In the event there is any material change in the answers to the questions herein prior to the issuance date of the Policy that would render this application form inaccurate or incomplete, the Applicant will notify the Insurer in writing, and, if necessary, any outstanding quotation may be modified or withdrawn.

The application must be signed by and dated by an authorized officer, partner, or principal of the Applicant.

Applicant Organization: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**ADDITIONAL INFORMATION:**



### CLAIM SUPPLEMENTAL APPLICATION

Please read this entire Supplemental Application carefully before signing. Whenever used in this Supplemental Application, the term "Applicant" means the Named Insured(s). Please complete ONE Supplemental Application for EACH claim or incident.

Name of Applicant: \_\_\_\_\_

1. Name(s) of Claimant(s) or potential Claimant(s): \_\_\_\_\_

2. Name of Defendant(s) or potential Defendant(s): \_\_\_\_\_

3. Indicate: Incident (potential claim)      Claim      Lawsuit

(a) Date of alleged wrongful act, error or omission: \_\_\_\_\_

(b) Date Applicant became aware of the alleged wrongful act, error or omission: \_\_\_\_\_

(c) How did the Applicant become aware of the alleged wrongful act, error or omission:

4. Has the matter been reported to the current carrier:      Yes      No

Carrier Name : \_\_\_\_\_

Date Reported: \_\_\_\_\_

5. This matter is      Open      Closed

(a) If Closed, indicate the Total:

(1) Expense paid: \$ \_\_\_\_\_

(2) Damages paid: \$ \_\_\_\_\_

(b) If Closed indicate if:      Court Judgment      Out of Court Settlement      Withdrawn

(c) If Open, indicate the Claimant Settlement Demand, if any: \$ \_\_\_\_\_

(d) If Open, indicate the Settlement amount offered by the Applicant: \$ \_\_\_\_\_

(e) If Open, indicate the amount of legal expenses paid to date: \$ \_\_\_\_\_

(f) If Open, indicate the Insurer's reserve for:

(1) Expenses: \$ \_\_\_\_\_

(2) Damages: \$ \_\_\_\_\_

6. Provide a detailed description of the claim or incident, including the allegations against the Applicant:

7. Please explain the corrective actions taken to prevent a similar claim or incident from reoccurring:

8. Attach a loss history report covering the last five (5) years if available

By signing this Supplemental Application, the Applicant understands and agrees that the information submitted herein and all attachments becomes a part of, is deemed attached to, and is subject to the same representations and conditions of, its application for professional liability insurance.

This Supplement Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.

Applicant Organization: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_