



## INSURANCE PROFESSIONALS ERRORS & OMISSIONS AND RELATED PROFESSIONAL LIABILITY INSURANCE APPLICATION



THIS IS AN APPLICATION FOR INSURANCE WRITTEN ON A "CLAIMS MADE" BASIS WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED WHILE THE POLICY IS IN FORCE.

1. Name of Applicant: \_\_\_\_\_
2. Street Address: \_\_\_\_\_ P.O.Box \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_ Individual    \_\_\_\_ Partnership    \_\_\_\_ Corporation    Federal I.D.# \_\_\_\_\_

3. Attach a list of any DBA's or other names used in the business and identify type of business relationship to Applicant.
4. List the following information and identify all owners, partners, officers, directors, and licensees: (attach a separate sheet if necessary, along with resumes on each individual)

NAME	TITLE	YEARS OF INS. EXPERIENCE	LICENSE #	% OF OWNERSHIP

5. (a) Limit of Liability Desired: **(000's omitted)**

25/50	100/300	1 Mil/1 Mil	Other:
50/100	500/1 Mil	Other:	

5. (b) Deductible Desired:

5,000	15,000	Other:	
10,000	20,000	Other:	

6. Applicant's License Number(s):    Agent: # \_\_\_\_\_    Surplus Lines: # \_\_\_\_\_    Life & Health: # \_\_\_\_\_  
(Attach a copy of each license.)

7. Date First Licensed: \_\_\_\_\_    Date Firm Was Established: \_\_\_\_\_

8. State the Applicant's Annual Premium Volume and Income:    (along with most recent annual financial statements)

	LAST YEAR	ESTIMATE THIS YEAR
<b>PREMIUM VOLUME</b>		
<b>GROSS COMMISSION INCOME</b>		
<b>NET COMMISSION INCOME*</b>		
<b>OTHER INCOME (DESCRIBE)</b>		

\*After deducting commissions paid to others not proposed for insurance hereunder

9. State the approximate percentage breakdown of total annual volume:

PERSONAL LINES	
Non-Standard Auto	%
Homeowners	%
Dwelling	%
Standard Auto	%
Total Personal Lines	%

SPECIALTY LINES	
Aviation	%
Professional Liability	%
Surety	%
Other:	%
Total Specialty Lines	%

COMMERCIAL LINES	
Casualty (GL/Umbrella)	%
Property/Package	%
Commercial Auto	%
Trucking-Long Haul	%
Inland Marine	%
Workers Comp	%
Other (Explain):	%
<b>TOTAL COMMERCIAL LINES</b>	<b>%</b>

LIFE AND HEALTH	
Life Individual	%
Life Group	%
A & H Individual	%
A & H Group	%
Annuities	%
Other (Explain):	%
Other (Explain):	%
<b>TOTAL LIFE &amp; HEALTH</b>	<b>%</b>

10. Business written directly for your own Insureds: \_\_\_% Business accepted from other agents and brokers: \_\_\_%
11. List all Companies with whom the applicant places business directly (other than MGA'S or wholesalers). (Attach separate sheet if necessary)

COMPANY					
DOMICILE					
BEST RATING					
DATE APPOINTED					
LINES OF BUSINESS					
PREMIUM **					

\*\* Premium Volume For Last Accounting year.

12. List all Surplus Lines Brokers and MGA's with whom you place business: (Attach separate sheet if necessary)

NAME	LINES PLACED	PREMIUM LAST ACCOUNTING YEAR

13. Have any Companies canceled or non-renewed the Agency relationship in the past three years? \_\_\_ Yes \_\_\_ No  
If yes, please explain (attach separate sheet if necessary): \_\_\_\_\_
- \_\_\_\_\_

14. Are you engaged in any of the following operations?

OPERATIONS	YES	NO	PREMIUM	GROSS COMMISSIONS	NET COMMISSIONS ***
Managing General Agent					
Wholesale Brokering					
Mutual Funds Sales					
Real Estate Funds					

\*\*\* After deducting commissions paid to others not proposed for insurance hereunder.

15. Agency staffing:

STAFF POSITION	TOTAL NUMBER	LICENSED	UNLICENSED	INDEPENDENT CONTRACTORS
Principal/Officers				
Agents/Brokers/Solicitors				
Service/Raters				
Accounting/Bookkeeping				
Clerical/Filing				
Other:				
<b>TOTAL</b>				

16. Are all employees who have customer contact licensed?      \_\_\_ Yes      \_\_\_ No

17. Attach copy of most recent annual financial statement and indicate:  
 The volume of Accounts Receivable as of Application Date: \_\_\_\_\_ Over 60 Days Old: \_\_\_\_\_

18. Please indicate functions performed by computer automation:    In-house \_\_\_\_\_      Outside Service \_\_\_\_\_

ACCOUNTING		CLAIMS		OTHER:	
RATING INFORMATION		LOSS HISTORY		OTHER:	
POLICY INFORMATION		MARKETING		OTHER:	

19. List all Professional Liability, E & O, or Legal Expense Insurance carried during the past 5 years. (If none, state "NONE".)

INSURANCE COMPANY	LIMITS OF LIABILITY	DEDUCTIBLE	PREMIUM	INCEPTION	EXPIRATION

20. Have any claims or suits been made during the past five years against the applicant or any of its predecessors in business, or any of the past or present partners, directors, officers, solicitors or employees?    \_\_\_ Yes    \_\_\_ No  
**(If yes, please attach a "CLAIM DATA SHEET".)**

21. Is the applicant, after inquiry of each person proposed for insurance, aware of any circumstance, error, omission, or offense which may result in a claim being made against the applicant or any of its predecessors in business, or any of the past or present partners, directors, officers, solicitors or employees?    \_\_\_ Yes    \_\_\_ No **(If yes, attach an explanation.)**

22. Has any application for insurance, on behalf of the applicant or any of its predecessors in business, been declined or canceled, or renewal of such insurance been refused?    \_\_\_ Yes    \_\_\_ No **(If yes, attach an explanation.)**

23. Has the applicant or any person or employee of any applicant proposed for insurance ever been subject to disciplinary action by any State Licensing Agency or other regulatory body?    \_\_\_ Yes    \_\_\_ No **(If yes, attach an explanation.)**

24. Has the applicant been involved in bankruptcy proceedings?    \_\_\_ Yes    \_\_\_ No **(If yes, attach an explanation.)**
25. Indicate all Insurance Professional Associations of which applicant or proposed individual Insureds are a member:  
\_\_\_\_\_
26. The Applicant declares that any event, occurrence that happens prior to the effective date of coverage which may cause any statement to be untrue or incomplete will be reported in writing to the insurer's representative. Further, the applicant declares that receipt of such report by the insurer's representative is a condition precedent to coverage.
27. Proposed Effective Date: \_\_\_\_\_  
Do you desire prior acts coverage?    \_\_\_ Yes    \_\_\_ No    If yes, please provide date: \_\_\_\_\_
28. What is the retroactive date of your expiring policy? \_\_\_\_\_  
Since what date have you had continuous coverage with no gaps? \_\_\_\_\_  
**PLEASE SUBMIT A COPY OF YOUR EXPIRING POLICY SHOWING ITS RETROACTIVE DATE.**
29. The Applicant accepts notice that any policy issued will:
- (1) Apply on a claims made basis only.
  - (2) The limits of liability includes claims expense.
  - (3) The deductible will apply to claims expense.

I/we hereby declare that the above particulars and statements are true and that I/we have not omitted or suppressed or misstated any material facts and that at the present time, I/we have no reason to anticipate any claim being brought against me/us for any error or omission on the part of me/us or any proposed insured and, agree that this Application Form shall be the basis of any policy of insurance which may be issued by the company and shall be deemed a part thereof; one signed copy to be attached to the policy, if issued.

**THE LIMITS OF LIABILITY STATED IN THIS POLICY INCLUDE THE COST OF CLAIMS EXPENSE AND MAY BE REDUCED OR EXHAUSTED BY SUCH COSTS AND IN SUCH EVENT THE COMPANY SHALL NOT BE LIABLE FOR THE COSTS OF CLAIMS EXPENSE OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT TO THE EXTENT THAT SUCH EXCEEDS THE LIMITS OF LIABILITY OF THE POLICY. IF THERE IS A DEDUCTIBLE AMOUNT SHOWN IN THE DECLARATIONS, CLAIMS EXPENSE COSTS INCURRED IN THE DEFENSE OF ANY CLAIM WILL BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.**

The Applicant hereby authorizes the Company, by signing this application, to contact any prior insurer and obtain any details, or prior loss information, or obtain any other information from any other source, which the Company deems important in the underwriting of the insurance applied for by this application.

Arkansas Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

It is agreed that the signature to this form does not bind the company nor the applicant to complete this insurance.

NAME OF APPLICANT: \_\_\_\_\_  
Signature of the Owner, Partner or President
Title
Date