



Insurance Agents and Brokers Professional Liability

INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABILITY APPLICATION

All questions must be answered and application must be signed by applicant. This is an application for Claims-Made Insurance.

PART I - AGENCY DETAILS

- 1. Agency Name:
Home Office Address:
City: State: Zip Code:
Phone Fax: Website:
2. a. Does the applicant have any branch offices or subsidiaries?
b. Is the applicant firm controlled, owned, affiliated or associated with any other firm, corporation or company?
c. During the past 5 years has the name of the firm been changed or has any other business been acquired, merged into, or consolidated with the original firm?
3. Date Established
4. Total number of personnel for each category:

PART II - AGENCY OPERATIONS

- 5. Please give the approximate percentage breakdown of the total of your premium volume and fees as:
6. Do you derive income from any activity/profession other than the sale of insurance products?
7. Do you currently act or have you acted in the past five years as an MGA, Third Party Administrator, Reinsurance Intermediary, or provided services for a fee as a Risk Manager/Consultant?

**PART III - PREMIUM VOLUME INFORMATION**

8. List ALL Insurance Companies with which your Agency places business: (Use attachment if necessary.)

Insurance Company	Direct Placement?		Total Annual	AM Best Rating	Admitted Carrier	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Premium Volume		<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

9. Are there any insurance carriers with which agency contracts have been terminated in the last 5 years and with which 25% or more of your annual premium was placed.  Yes  No

(If Yes, attach an explanation for each termination.)

10. Breakdown of annual written premium volume by line of coverage, and gross receipts if applicable as of this date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**By signing this application, the Applicant represents that the written premium figures, and gross receipts if applicable provided in question 10 are an accurate reflection of written premium at the time of signing the application. The Applicant further agrees to provide, at the Company's request, full disclosure of the agency's books and records for premium audit purposes. If an audit reveals a material change in premium than stated on the application, then the company is entitled to collect additional earned premiums, cancel or rescind coverage.**

<b>10a. PERSONAL LINES:</b>		Volume	Trusts including Workers Compensation	
Automobile - Standard	\$ _____		Trusts, MET's, MEWA's, etc	\$ _____
Automobile - Non-standard (including Assigned Risk, JUA'S, etc.)	\$ _____		Risk Retention Plans	\$ _____
Homeowners - Standard	\$ _____		Crop / Hail	\$ _____
Homeowners - Non-standard (including Fair Plans)	\$ _____		Other (Describe)	\$ _____
Personal Umbrella	\$ _____		<b>TOTAL COMMERCIAL LINES</b>	\$ _____
Other (describe)	\$ _____		<b>10c. LIFE/ACCIDENT/HEALTH LINES:</b>	
<b>TOTAL PERSONAL LINES</b>	\$ _____		Life, Individual.	\$ _____
			Life, Group	\$ _____
<b>10b. COMMERCIAL LINES:</b>			Accident, Disability & Health, Individual	\$ _____
Workers Compensation	\$ _____		Accident, Disability & Health, Group	\$ _____
Long Haul Trucking	\$ _____		<b>TOTAL LIFE/ACCIDENT/HEALTH LINES</b>	\$ _____
Commercial Auto (including Livery)	\$ _____		<b>TOTAL ALL LINES</b>	\$ _____
Commercial General Liability	\$ _____		<b>10d. INVESTMENT INCOME</b>	
BOP (Businessowners policy)	\$ _____		List total gross receipts for the past twelve months for the following activities:	
Commercial Property	\$ _____		Fixed Annuities	\$ _____
Ocean/Wet Marine	\$ _____		Variable Annuities	\$ _____
Inland Marine	\$ _____		Mutual Funds	\$ _____
Bonds	\$ _____		Stocks	\$ _____
Aviation	\$ _____		Bonds	\$ _____
Commercial Umbrella / Excess	\$ _____		Commodities	\$ _____
Physicians & Hospitals	\$ _____		Financial Plans for a Fee	\$ _____
Professional Liability	\$ _____			

**ONLY ANSWER QUESTIONS #11-14 IF VOLUME IS LISTED UNDER QUESTION #10c (LIFE/ACCIDENT/HEALTH LINES).**

11. How many times in the past 12 months have you replaced an existing Life Insurance policy with a new policy? \_\_\_\_\_  
 Why were these policies replaced? \_\_\_\_\_

12. Is applicant involved in the ownership, formulation, creation, administration, or operation of any self-insurance fund or program, Multiple Employer Trust, Multiple Employer Welfare Arrangement, pool, syndicate, association or other combination formed for the purpose of providing insurance or benefits when they are not fully funded by an insurance product?  Yes  No  
 If Yes, advise details \_\_\_\_\_

13. If you place or service any Group Life, Accident or Health insurance, what is the largest plan (based on number of participants) that you handle? \_\_\_\_\_
14. Is the applicant a captive agent?  Yes  No  
 Is applicant employed by any insurance company?  Yes  No  
 If yes to either, please answer the following.  
 a. Please list the name of this company: \_\_\_\_\_  
 b. Is professional liability already provided for business placed with this company?  Yes  No

**ONLY ANSWER QUESTIONS #15-17 IF INCOME IS LISTED UNDER QUESTION #10d (INVESTMENT INCOME).**

15. Do you have discretionary control of any clients' assets?  Yes  No  
 If yes, indicate the number of clients and the value of assets controlled: \_\_\_\_\_
16. Are you involved in the sale of structured settlement annuities?  Yes  No
17. Do you have any involvement in the development or solicitation of general or limited partnerships?  Yes  No  
 If yes, provide full details: \_\_\_\_\_
18. What percentage of the premium volume listed in question 10 is written on a non-admitted basis? \_\_\_\_\_  
 (Do not include Assigned Risk, JUA'S, and Fair Plans)
19. a Does the Total Insured Value of any Commercial Property or Inland Marine account written by the applicant exceed one million dollars (\$1 million)?  Yes  No  
 (If yes, please attach a list of accounts including the total insured value.)  
 b Do any classes of business account for over 10% of the applicant's commercial premium volume?  
 Bars/ Taverns/ Restaurants  Yes  No  
 Contractors  Yes  No  
 Other (please specify)  Yes  No \_\_\_\_\_

**PART IV - CLAIM INFORMATION**

Do not complete this section if this is an application for a renewal policy at the same limit of liability with one of the USLI Companies.

20. During the past five (5) years, has any claim been made or suit brought against the agency, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees, or independent contractors?  Yes  No  
 (If yes, provide details on the separate supplemental claims application.)
21. Is any owner, partner, officer, director, employee, or independent contractor aware of any circumstance, allegation, contention, or incident which may result in a claim being made against the agency, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees, or independent contractors?  Yes  No  
 (If yes, provide details on the separate supplemental claims application.)

**PART V - INSURANCE COVERAGE INFORMATION**

22. Has any prospective insured ever had their license revoked or suspended or been fined or disciplined in any way or been the subject of any investigation by any state insurance department?  Yes  No  
 (If yes, please attach an explanation.)
23. During the past five years, has any director, officer, partner, employee, or independent contractor ever been declined, cancelled or refused renewal of their fidelity or surety bond?  Yes  No  
 If yes, provide full details: \_\_\_\_\_
- 
24. Has any policy of or application for similar insurance on your behalf or on the behalf of any of your principals, officers, employees, or on behalf of any predecessors in business ever been declined, canceled, or renewal refused?  Yes  No  
 (If yes, please attach an explanation.)

25. Please provide the following information on your professional liability insurance for the past three years:

Name of Insurer	Limit	Deductible	Policy Period	Premium
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

26. Retroactive Date of current policy (if any): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

27. Have you ever purchased "Extended Discovery/Reporting Period" coverage ("tail") from any prior insurer?  Yes  No  
(If yes, please attach an explanation.)

**Virginia Notice:** You have an option to purchase a separate Limit of Liability for the extension period, policy common conditions VII. If you do not elect this option, the Limit of Liability for the extension period shall be part of and not in addition to the limit specified in the declarations. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

**Minnesota Notice:** The clause "and/or authorization or agreement to bind the insurance." is replaced with "Authorization or agreement to bind the insurance may be withdrawn or modified based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

**Colorado Fraud Statement:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia Fraud Statement: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Fraud Statement:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky Fraud Statement:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**Maine Fraud Statement:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**New Jersey Fraud Statement:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New York Fraud Statement:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Ohio Fraud Statement:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Fraud Statement: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania Fraud Statement:** 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.

**Tennessee and Virginia Fraud Statement:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Fraud Statement (All Other States):** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New York Disclosure Notice:** This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged wrongful acts that took place prior to the retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extended reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

If the primary address of the location listed in item #1 is in the state of **New York, Iowa or Florida**, the states of **New York, Iowa and Florida** require that we have the name and address of your (insured's) authorized Agent or Broker.

Name of authorized Agent or Broker: \_\_\_\_\_

Address: \_\_\_\_\_

Agent or Broker License number: \_\_\_\_\_

Mail completed Application through local Agent or Broker to: \_\_\_\_\_

The undersigned declares that to the best of his/her knowledge and belief the statements set forth herein are true, The undersigned further declares that any occurrence or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Insurer and the Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the policy.

Signature of Applicant: \_\_\_\_\_

Must be signed by a Principal, Partner or Officer of the Firm

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



# Insurance Agents and Brokers Professional Liability

## INSURANCE AGENTS AND BROKERS SUPPLEMENTAL CLAIMS APPLICATION

Please complete this form in its entirety for all prior and pending E&O claims.

1. Name of claimant: \_\_\_\_\_
2. Date claim occurred: \_\_\_\_\_
3. Date claim reported to E&O Carrier: \_\_\_\_\_
4. Details and background of claim: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. What is the status of the claim? \_\_\_\_\_
6. Defense costs paid to date: \_\_\_\_\_
7. Settlement amount: \_\_\_\_\_
8. If claim is still open, what is the reserve amount? \_\_\_\_\_
9. What remedial measures have been taken to prevent a recurrence of a similar claim?  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(Principal, Partner or Officer of the Firm)

**The information on this supplemental application is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as if physically attached hereto.**



# Insurance Agents and Brokers Professional Liability

## LIFE/ACCIDENT/HEALTH AGENTS SUPPLEMENTAL APPLICATION

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

Name of Partners, Principals, Producers, Independent Contractors selling Life/Accident/Health products	Title	Type of License	Date Licensed	# of Years of Related Experience

**1. Life/Accident/Health Lines:**

Life, Individual . . . . . \$ \_\_\_\_\_  
 Life, Group . . . . . \$ \_\_\_\_\_  
 Accident, Disability & Health, Individual . . . . . \$ \_\_\_\_\_  
 Accident, Disability & Health, Group . . . . . \$ \_\_\_\_\_  
 Total Life/Accident/Health Lines Premium . . . . . \$ \_\_\_\_\_  
 Total Life/Accident/Health Lines Commission . . . . . \$ \_\_\_\_\_

2. How many times in the past 12 months have you replaced an existing Life Insurance policy with a new policy? \_\_\_\_\_

Why were these policies replaced? \_\_\_\_\_

3. If you place or service any Group Life, Accident or Health insurance, what is the largest plan (based on the number of participants) that you handle? \_\_\_\_\_

4. Is the applicant involved in the ownership, formulation, creation, administration, or operation of any self-insurance fund or program, Multiple Employer Trust, Multiple Employer Welfare Arrangement, pool, syndicate, association or other combination formed for the purpose of providing insurance or benefits when they are not fully funded by an insurance product? Yes No

If Yes, please provide details. \_\_\_\_\_

THIS SUPPLEMENTAL APPLICATION IS ATTACHED TO AND FORMS PART OF THE PROFESSIONAL LIABILITY APPLICATION FOR CLAIMS-MADE INSURANCE. THIS SUPPLEMENT IS SUBJECT TO THE SAME PROVISIONS CONCERNING REPRESENTATIONS MADE IN THE GENERAL APPLICATION.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative



# Insurance Agents and Brokers Professional Liability

## FINANCIAL PLANNERS ADDENDUM TO APPLICATION

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

Name of Partners, Principals, Producers, Independent Contractors selling Life/Accident/Health products	Title	Type of License	Date Licensed	# of Years of Related Experience

1. Investment Income

List the total gross receipts for the past twelve months derived from the sales of the following products and/or activities:

Fixed Annuities \$ \_\_\_\_\_  
 Variable Annuities \$ \_\_\_\_\_  
 Mutual Funds \$ \_\_\_\_\_  
 Stocks \$ \_\_\_\_\_  
 Bonds \$ \_\_\_\_\_  
 Commodities \$ \_\_\_\_\_  
 Financial Plans for a fee \$ \_\_\_\_\_  
 TOTAL \$ \_\_\_\_\_

2. Do you have discretionary control of any client's assets?  Yes  No

If yes, indicate the number of clients and the value of assets controlled: \_\_\_\_\_

3. Are you involved in the sale of structured settlement annuities?  Yes  No

4. Do you have any involvement in the development or solicitation of general or limited partnerships?  Yes  No

If yes, provide full details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

THIS SUPPLEMENTAL APPLICATION IS ATTACHED TO AND FORMS PART OF THE PROFESSIONAL LIABILITY APPLICATION FOR CLAIMS-MADE INSURANCE. THIS SUPPLEMENT IS SUBJECT TO THE SAME PROVISIONS CONCERNING REPRESENTATIONS MADE IN THE GENERAL APPLICATION.

\_\_\_\_\_

Date

\_\_\_\_\_

Authorized Representative