

UNITED STATES LIABILITY INSURANCE GROUP

Management/Marketing Consultants Supplemental

APPLICATION

•	Does the Applicant plan to or has the Applicant 1) Consulted on mergers, acquisitions, capital	ization, or liqu	uidation's? Yes □ No				
	Prepared, reviewed or approved architecture maps, plans, opinions, estimates, surveys, otherwise been involved with the design, co	designs or sp	ecifications or				
	if any building or structure?						
	3) Primary activity is to consult on downsizing						
	4) Been involved in any financial or environment						
	5) Been involved in the management, purchas						
	any real estate?						
	Please indicate the percentage of Applicant's annual revenue from the last fiscal period involving: (total must equal 100%).						
	Executive Search/Recruiting _	%	Attitude and Opinion Surveys	%			
	Human Resource Consulting	%	Competitive Analysis	%			
	Education/Training _	%	Customer Service	%			
	Quality Improvement/Quality Control _	%	Mailing List/Telemarket List				
	Business Communication _	%	Development	%			
	Administrative/Office Services	%	Marketing Research	%			
	New Product Marketing	%	Telemarketing Sales	%			
	Feasibility Studies	%	Downsizing/Rightsizing Planning	%			
	Management Audits	%	Financial Planning	%			
	Management/Ownership Succession		Long Term Projects/Planning	%			
	Planning _	<u></u> %	Mergers and Acquisitions	%			
	Computer Consulting	%	Product Testing	%			
	Does the Applicant provide any services other	than those se	ervices listed above in #3? Yes 🔘 No				
	If yes, please provide details on a separate sheet.						
~	IO MANA OFMENTALA BYETINO CONSULTAN	TO: 011551 F	AASNITAL ABBUIDATION IS ATTAOUS				
	IS MANAGEMENT/MARKETING CONSULTAN RT OF THE PROFESSIONAL LIABILITY FOR						
۰,			RESENTATIONS MADE IN THE BASIC				



UNITED STATES LIABILITY INSURANCE GROUP

Consultants Professional Liability

APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

SECTION I - BACKGROUND INFORMATION

s A.J.J	e of Insured:					
2. Addre	ess:					
Web :	Site:					
3. Limits	s of Liability desired: \$250,0	0 🗆 \$500,000 🗆 \$1,000,000				
I. Deductible: □ \$1,000 □ \$2,500 □ \$5,000 □ \$10,000						
	Established:					
6. Is Insured:						
	·	ated or associated with any other firm, corporation or company?				
	□ No □					
B. Does	the Applicant have any Subsidia	ies? Yes □ No □ If Yes, please list on a separate sheet and advise if				
	age is to apply to them.	•				
	During the past five years has the name of the firm been changed or has any other business been acquired, merged into or consolidated with any other firm, corporation or company? Yes \Box No \Box (If yes, please attach an					
	-	have been assumed as a result of the merger, acquisition or consolidation).				
•	•	II - ORGANIZATION OPERATIONS DETAILS				
عمما ۱۸		nal services for which coverage is desired:				
o. i leas	ie describe in detail the profession	ar services for which coverage is desired.				
-		·				
11. (a) Li	ist total gross receipts derived fro	m activities in question #10:				
(, , , , ,	,	Gross Receipts				
Last \	Year:	\$				
Curre	ent Year (based on 12 months):	\$				
	east for Next Year:	\$				
(b) D	loes the Applicant receive any co	npensation other than money (stock, options) for providing professional				
Se	services? Yes No If Yes, advise details.					
2. (a) D	(a) Does the Applicant derive income from any activity or profession other than what is described in question #10?					
Y	Yes No If Yes, please attach an explanation and estimated receipts (advise if these receipts were					
in	cluded in question #10).					
(b). Is	s the Applicant a licensed Profes	ional (i.e. Lawyer, Accountant) Yes <a> No If Yes, advise type of				
li	icensed Professional:					
3. (a). [(a). Describe the (5) five largest jobs or projects during the past 3 years					
f	NAME OF CLIENT	SERVICES PROVIDED GROSS BILLINGS/FEES				
-						
	1					
	Also more than 50% of Applicant					
٠,	• •	total gross billings for any one year derived from a single client or contract?				
٠,	• •					
Y	/es □ No □ If Yes, specify	total gross billings for any one year derived from a single client or contract? lient, services rendered and how long relationship is expected to continue:				
(c). D	res □ No □ If Yes, specify Describe any jobs or projects anti	total gross billings for any one year derived from a single client or contract?				

14.	(a). Advise the number of: principals, partners, officers and professional employees directly engaged in providing services to clients						
	(b) Advise the number of all other (non-professional/clerical) employees						
	(c) Advise the number of independent/sub contractors doing work on your behalf						
15.	Does the Applicant desire to provide coverage under this Policy for independent/sub contractors working on their						
	behalf? Yes No If Yes, advise on a separate sheet:						
	(a) How the Applicant utilizes each independent/subcontractor.						
	(b) The total percent of Applicant's work done by independent/sub contractors.						
	(c) Does the Applicant require Certificates of Insurance from all independent/sub contractors.						
16.	Please provide the following: (attach separate sheet if necessary)						
	Name of all Partners, Principals, Professional # of Years # of Years						
	Key Employees and Qualifications/ in Practice with Applicant						
	Independent/Sub Contractors. Designations						
17.	Does the Applicant design, manufacture or test any product or process for creating a product? Yes No						
	If Yes, provide details on a separate sheet.						
	Does the Applicant use a written contract with clients? ☐ In all cases ☐ Sometimes ☐ Never						
19.	Has the Applicant or independent contractor ever been dismissed from a project or contract prior to completion? Yes No If Yes, provide details on a separate sheet.						
20	Yes No If Yes, provide details on a separate sheet. Has the Applicant ever entered into contracts where fees were obtained by the client achieving certain cost						
20.	reductions or results in general? (If yes, please attach explanation).						
21	Does any director, officer, employee, partner or independent/sub contractor of the Applicant serve on the Board of						
۷١.	Directors of any client or own any financial or equity interest in any client of the Applicant? Yes No No No No No No No N						
	If Yes, please attach an explanation.						
	SECTION III - CLAIMS INFORMATION						
	not complete this section if this is an application for a renewal policy at the same limit of liability with one of the USLI						
	mpanies.						
22.	During the past (5) five 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/sub						
	contractors? Yes No (IF YES, PLEASE PROVIDE DETAILS ON THE SEPARATE SUPPLEMENTAL						
	CLAIMS APPLICATION.)						
23.	Is any owner, partner, officer, director, employee, or independent/sub 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 partners, owners, officers, directors, employees, or independent						
	contractors? Yes No (IF YES, PLEASE PROVIDE DETAILS ON THE SEPARATE SUPPLEMENTAL						
	CLAIMS APPLICATION.)						
	SECTION IV - PROFESSIONAL LIABILITY INSURANCE COVERAGE						
24.	Has any Policy of or Application for professional liability 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, advise details.						
25.	Is similar professional liability insurance currently in force? Yes □ No □ If Yes, please advise:						
	Name of Carrier Limit Deductible Premium Policy Period						
	Retroactive Date (if any):						
	SECTION V - GENERAL LIABILITY INFORMATION						
26.	Does the Applicant currently have General Liability Insurance? Yes No If yes, please advise the following:						
	Carrier Premium Expiration Date GL Losses						
	Yes No 🗆						
	Describe any General Liability Losses in past 5 years:						

28.	Number of Employed Consultants (a) Does the Applicant use Independent Contractors? Yes □ No □ If Yes, please answer 28 (b) and (c). (b) Is General Liability coverage to include Independent Contractors? Yes □ No □ (c) Number of Independent Contractor Consultants used (a) Is the Applicant involved in the installation of equipment or physical application of the items for which they are providing consultation services (including work done by Independent Contractors supplied by the Applicant)? Yes □ No □ If yes, please answer 29(b) and (c) below: (b) Describe installations or applications:						
	(D)	Decembe installations of applications.					
30.	(c) Costs of subcontracted work Are subcontractors required to have liability insurance? Yes □ No □ Are Certificates of Insurance maintained by the Insured? Yes □ No □ Additional Insureds to be included (List name, address and relationship to Applicant):						
31.	(a)	SECTION VI - PERSONAL PROPERTY INSURANCE INFORMATION Personal Property Limit Needed (at 80% Coinsurance/Replacement Cost)					
	(b .)	If Limit is greater than \$25,000, please answer 31 (b) and (c) below:					
	(D)	Protection Class (1 through 10)					
	(-)	Sprinklers Yes □ No □ Central Station Yes □ No □					
		Fire Alarm Yes No Central Station Yes No					
32.	If IO	cated in first tier coastal county, distance from water (ocean, bay or inlet) Premium \$ vious Carrier: Premium \$					
34.	Pro	perty Claims Paid or Pending during last 5 years (by year)					
	SECTION VII - REQUIRED INFORMATION Please submit each of the following items with the Submission: A. USLI Application.						
		Copy of Financial Statement.					
		Copy of Applicant's formalized standard client contract. Copy of resumes on technical and key personnel.					
		Marketing materials/brochures.					
CO	NCEF	STATEMENT: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR ICE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION INING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT SEED FIVE THOUSANDS DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.					
THE STATES OF NEW YORK AND FLORIDA REQUIRES THAT WE HAVE THE NAME AND ADDRESS OF YOUR (INSURED'S) AUTHORIZED AGENT OR BROKER. NAME OF AUTHORIZED AGENT OR BROKER							
ADDRESS							
LICENSE NO.							
MAIL COMPLETED APPLICATION THROUGH LOCAL AGENT OR BROKER TO:							
or r not App by t bind It is bas	ner of the, undiffered required ficat the in the und so of	NOTICE TO THE APPLICANT ersigned declares that to the best of his/her knowledge and belief the statements set forth herein are true. The undersigned eclares that any occurrence or event taking place prior to the effective date of the insurance applied for which may render inacontrue, or incomplete any statement made will immediately be reported in writing to the insurer and the insurer mat withdraw years outstanding quotations and/or authorization or agreement to bind the insurance. The Insurer is hereby authorized, but itred, to make an investigation and inquiry in connection with the information, statements and disclosures provided in this on. The decision of the insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights surer and shall not estop the insurer from relying on any statement in this Application. The signing of this Application does not undersigned to purchase the insurance, nor does the review of this Application bind the insurance company to issue a policy estood the insurer is relying on this Application in the event the Policy is issued. It is agreed that this Application shall be the the contract should a policy be issued and it will be attached and become part of this policy. **Date:**					
	Must be signed by a Principal, Partner or Officer of the Firm CONSA (8/97)						
CONS	A ((5/9/)					

(FAX

NAME:	
COMPANY:	
ADDRESS:	
STATE, ZIP:	
DATE:	
DATE: NUMBER OF PAGES(incl. Cover):	
* EAV TO:	
* FAX TO:	
PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST * Click the link below for a list of our offices and current fax numbers.	YOU.
http://www.qsr-insurance.com/qsr-fax.html	
ADDITIONAL COMMENTS:	
ADDITIONAL COMMENTS.	