INSURANCE PROFESSIONALS ERRORS & OMISSIONS AND RELATED PROFESSIONAL LIABILITY INSURANCE APPLICATION

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

1. Name of Applicant: _____

   Attach list of any dba's or other names used in the business and identify the type of business relationship to the Applicant. List all locations other than the one listed in question 4 on a separate sheet.

2. Please check the corporate structure: ☐ Individual ☐ Partnership ☐ LLC ☐ Corporation, Federal ID#_____
   ☐ Other, describe: _____

3. Website Internet Address (URL), if any: _____

4. Street Address: _____ P.O. Box _____
   City, State, Zip: _____ County: _____
   Telephone Number: (____) _____ Fax Number: (____) _____

5. Is the Applicant owned by, controlled by or affiliated by common ownership with any another entity? ☐Yes ☐No
   (If yes, give details on a separate sheet and include name of entity, percentage owned/controlled, etc.)

6. Within the last five years, has the name of the Applicant been changed or has any other business been purchased, merged or consolidated with the Applicant? ☐Yes ☐No (If yes, give details on a separate sheet.)

7. Provide names of all owners, partners, officers, directors and licensees in the chart below (attach a separate sheet if necessary):

NAME	TITLE	INSURANCE EXPERIENCE (Years)	DATE FIRST LICENSED - specify P&C or Life/Accident/Health	LICENSE NUMBER	OWNERSHIP (percentage)

8. Date agency was established _____ (If new/start-up, please provide a resume of all agency principals.)

9. Agency Staffing:

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

10. Are all employees who have customer contact licensed? ☐ Yes ☐ No

11. Complete the Production Chart below (and provide the most recent annual financial statement):

	LAST YEAR	ESTIMATE THIS YEAR
TOTAL GROSS ANNUAL P&C PREMIUM VOLUME		
TOTAL GROSS ANNUAL P&C COMMISSIONS		
TOTAL GROSS ANNUAL LIFE & HEALTH COMMISSIONS		
OTHER INCOME (DESCRIBE):		

12. State the appropriate percentage breakdown of total annual volume (**Total for A + B + C + D should equal 100%):**

PROPERTY & CASUALTY	
A. Personal Lines	
Non-Standard Auto	**%**
Standard Auto	**%**
Homeowners	**%**
Dwelling	**%**
Umbrella	**%**
Pleasure Boats/Crafts	**%**
Recreational Vehicles/Motorhomes	**%**
Other (explain)	%
Personal Lines total	**%**

B. Commercial Lines	
Casualty (GL/Umbrella)	%
Property/Package	%
Auto	%
Long-Haul Trucking	%
Inland Marine	%
Workers Compensation	%
Aviation	%
Professional Liability	%
Bonds – Surety	%
Bonds – All others (describe)	%
Crop	%
Other (explain)	%
Commercial Lines total	%

LIFE/ACCIDENT/HEALTH & FINANCIAL SERVICES	
C. Individual Life/Accident/Health	
Individual Health	%
Individual Disability	%
Individual LTC	%
Accidental Death & Dismemberment (AD&D)	%
Fixed Annuities	%
Variable Annuities	%
Indexed Annuities	%
Individual Term Life	%
Individual Perm Life (Whole & Universal)	%
Credit Life	%
Stranger- Owned Life (STOLI)	%
Other (explain)	**%**
Individual Life/Accident/Health total	%

D. Group Life/Accident/Health & Financial Services*	
Group Life	%
Group Disability	%
Group Dental	%
Group Health (Fully-Insured)	%
Group Health (Self-Insured)	%
Stop Loss/Reinsurance	%
PEO's/MEWA's/MET's/VEBAs/Taft-Hartley	%
IRA's	%
Pension Plans	%
401 K's	%
Mutual Funds**	%
Stocks, Trade Bonds, Options, Etc.	%
Other (explain)	%
Group Life/Accident/Health & Financial Services total:	**%**

***If any, complete Group Life/Accident/Health & Financial Services Underwriting Supplement**

****For Mutual Funds, provide name of Broker Dealer**

13. Does the Applicant **specialize** in any class of risk (e.g. oil & gas, environmental, auto dealers, contractors, etc.)? ☐ Yes ☐ No
If yes, what class? _____

14.	**In the past five (5) years has the Applicant**:	**YES***	**NO**	**N/A**
a.	Designed, administered or placed business in any insurance captives, reciprocals, pools, risk retention groups, and/or risk purchasing groups?			
b.	Been involved with the ownership, formation, operation or administration of any insurance company, health maintenance organization (HMO), preferred provider organization (PPO) or self-insured program?			
c.	Sold annuities in Structured Settlement Arrangements?			
d.	Been involved in the sale of life insurance policies to a viatical company, or been involved in the investing or servicing of viatical products?			
e.	Acted as a named fiduciary?			

(*If yes, provide a detailed explanation on a separate sheet.)

15. What percentage of the Applicant's book is written as:
    a. Retail (Business sold directly to your Insureds): _____%
    b. Wholesale (Business placed for other agents): _____%
    c. MGA (Business for which you have underwriting authority)* _____%
    * Must complete the MGA supplement

16. Provide the names of the Applicant's top 5 clients, industry for each, line of business placed for each and premium volume/revenue the agency earned from each:

Top 5 Client Name	Industry	Line of Business Placed	Premium Volume/Revenue

17. List all Companies with whom the Applicant places business on a direct basis (other than MGA's or Wholesalers). (Attach separate sheet if necessary.)

Company Name	Date Appointed	Binding Authority (Yes/No)	Current A.M. Best rating	Lines of Business	Percentage of Total Revenue
		☐ Yes ☐No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			
		☐ Yes ☐ No			

18. List all carriers that either the Applicant or Company has terminated the relationship with during the past five (5) years and provide reason for termination, If none, check here: ☐

    Terminated carriers _____

    Reason for termination _____

19. List all Surplus Lines Brokers and MGA's with whom the Applicant places business (attach a separate sheet if necessary):

SURPLUS LINES BROKER/MGA NAME	LINES PLACED	PREMIUM LAST ACCOUNTING YEAR

20. Does the Applicant perform any of the following activities? If yes, advise if it is only for the Applicant's Insurance clients. ***(Coverage may be excluded under policy***.)

OPERATIONS	YES	NO	Only for Applicant's Insurance Clients? YES or NO	REVENUE
Risk Management/Loss Control				
Premium Finance for Operations				
OSHA/Environmental Audits				
Reinsurance Intermediary				
Third Party Administrator (TPA)*				
Claims Adjustment Services				
Actuarial Services				
Tax Preparer/Accountant				
Real Estate Sales				

*Provide a copy of the TPA Contract

21. Please indicate the functions performed by computer automation:

	In-house	Outside Service		In-house	Outside Service
ACCOUNTING			**CLAIMS**		
RATING INFORMATION			**LOSS HISTORY**		
POLICY INFORMATION			**MARKETING**		

22. Office Procedures:

		YES	NO	N/A
a.	Does the Applicant have an office manual?			
b.	Is incoming mail date-stamped or otherwise marked to document the date it was received?			
c.	Are copies of binders mailed to the insured and/or the company within specified guidelines?			
d.	Is there a procedure for documenting telephone conversations to a client's file?			
e.	Are all applications, policies and endorsements, etc. checked for accuracy?			
f.	Are files marked to ensure certificate holders are notified of cancellation or material changes?			
g.	Does the Applicant have a diary/suspense system or some other method to "pend" items for follow-up?			
h.	Does the Applicant have a procedure in place to ensure disclosure of exclusions, including but not limited to: Mold/Fungus and War/Terrorism?			
i.	If the Agency is owned and operated by one individual, is a back-up plan in place for when the individual is not available to operate the Agency's day to day operations? **If yes, describe on separate sheet.**			

23. List all Professional Liability, E&O or Legal Expense Insurance carried by the Applicant during the past 3 years. If none, state "NONE".

INSURANCE COMPANY	LIMITS OF LIABILITY	DEDUCTIBLE	PREMIUM	INCEPTION	EXPIRATION

24. Proposed Effective Date:_____

Does the Applicant desire prior acts coverage? ☐ Yes ☐ No If yes, submit a copy of expiring policy showing retroactive date.

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

	250/500		**100/300**		**1 Mil/1 Mil**
	300/300		**500/1 Mil**		**Other:**

Deductible desired:

	2,500		**5,000**		**Other:**
	7,500		**10,000**		**Other:**

26. 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, attach CLAIM DATA SHEET**

27. 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.**

28. Has any application for insurance, on behalf of the Applicant or any of its predecessors in business been declined, cancelled or renewal of such insurance been refused? ☐ Yes ☐ No **If yes, attach an explanation.**

29. Has the Applicant or any person or employee of the 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**.

30. Has the Applicant been involved in bankruptcy proceedings? ☐ Yes ☐ No **If yes, attach an explanation.**

The Applicant declares that any event or 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.

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 or the Applicant to complete this insurance.

MUST BE SIGNED AND DATED BY OWNER, PARTNER OR SENIOR OFFICER OF THE AGENCY APPLYING FOR COVERAGE.

Name: _____ Title: _____

(Print Name) (Print Title)

Signature: _____ Date: _____

(Owner, Partner or Senior Officer) (Month/Day/Year)

Group Life/Accident & Health Underwriting Supplement

This underwriting supplement to be completed if the applicant provides services for any of the following plans (complete a separate underwriting supplement for each plan):

(1) Multi-Employer Trust, Professional Employer Organization (PEO) or MEWA
(2) Public/Government
(3) Taft-Hartley (Union)
(4) Health and Welfare plan
(5) Retirement/Pension plan

Plan Name _____

Year plan was established: _____ #of participants: _____

Type of plan (retirement/pension, profit sharing, health and welfare, etc): _____

What services does the applicant provide? _____

How long has the applicant been providing services to the plan? _____

(1) If a Multi-Employer Trust, Professional Employer Organization (PEO) or MEWA:
   a. Who formed the plan? _____
   _____
   b. How many employers are in the plan? _____
   _____

(2) If Public/Government plan:
   a. Name and type of entity: _____
   _____
   b. City/County/State: _____
   _____

(3) If a Taft-Hartley (Union) plan:
   a. What union are you working with and with what industry are they associated? _____
   _____
   b. City/County/State: _____
   _____

(4) If a Health and Welfare plan:
   a. Is the plan: (i) fully insured_____ (ii) partially insured_____ (iii) self-insured_____
   b. If (i) fully insured or (ii) partially insured, what insurance company provides the insurance? _____
   _____
   c. If (iii) self-insured, what insurance company provides the "stop loss" or other excess placement? _____
   _____

(5) If retirement/pension plan:

a. Is it a defined contribution or defined benefit plan?_____

b. Has a favorable IRS Plan Determination Letter been received? Yes _____ No _____

c. If No, please explain why not:_____

_____

d. What investment vehicles are used to fund the plan?_____

_____

e. Name of product provider(s) of the investment vehicles:_____

_____

f. Who is in the role of fiduciary when selecting the investments for the plan? _____

_____

g. Who is in the role of fiduciary when directing the investments for the plan? _____

_____

I understand information submitted herein becomes a part of the applicant and is subject to the same conditions as stated in the application. I also understand and agree that I am obligated to report any changes in the information provided in this supplement that occur after the date of the application and before policy inception.

MUST BE SIGNED AND DATED BY OWNER, PARTNER OR SENIOR OFFICER OF THE AGENCY APPLYING FOR COVERAGE.

Name: _____ Title: _____
(Print Name) (Print Title)

Signature: _____ Date: _____
(Owner, Partner or Senior Officer) (Month/Day/Year)

INDIVIDUAL CLAIM DATA REPORT

APPLICANT'S INSTRUCTIONS:

1. This form is to be completed by Applicant regarding any claim or suit during the past five (5) years or any facts, circumstances, acts, errors, or omissions of which applicant is aware which may give rise to a claim. COMPLETE ONE FORM FOR EACH SUCH CLAIM OR CIRCUMSTANCE.
2. If additional "Individual Claim Data Reports" are required, please photocopy blank report.
3. If space is insufficient to answer any question fully, attach a separate sheet.
4. Answer all questions completely.

(PLEASE TYPE OR PRINT)

1. Full name of Applicant:

   _____

2. Full name of individual(s) involved or named in the claim:

   _____

3. Full name of Claimant:

   _____

4. Indicate whether: Claim/suit:_____ Incident: _____
5. Date of alleged error:_____ Date of claim: _____
6. Additional defendant (if any):

   _____

7. IF CLOSED:

   Total Loss Paid including Deductible: $_____

   Legal Expenses Paid: $_____

8. IF PENDING:

   Claimant's settlement demand $_____ Loss reserves $_____

   Defendant's offer of settlement $_____ Loss paid to date $_____

   Expense reserves $_____ Expenses paid to date $_____

   Deductible $_____ Is claim in suit: Yes_____ No_____

   If Yes, Amount asked in summons? $_____

9. Name of Insurer (if any) :_____
10. Description of claim: (Provide enough information to allow evaluation and use back of this page or separate exhibit if additional space is required.)

    A. Alleged act, error or omission upon which claimant bases claim:

    _____

    _____

    B. Description of the type and extent or injury or damage allegedly sustained:

    _____

    _____

11. What preventative measures has the applicant implemented to ensure claims will not occur in the future?

_____

_____

_____

I understand information submitted herein becomes a part of the proposal and is subject to the same warranty and conditions.

Signature of Applicant_____ Date _____