

Insurance Professionals Errors & Omissions And Related Professional Services 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.

GENERAL INFORMATION

1. Name of Applicant: _____

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

2. Company Type: Individual Partnership LLC Corporation Other (describe): _____

3. Website: _____

4. Physical Address: _____
 City, State, Zip: _____
 Mailing Address: _____
 Telephone: _____ Fax: _____ Email: _____

5. Is the applicant owned by, controlled by or affiliated by common ownership with any other entity? If Yes, provide Details on a separate sheet and include name of entity, percentage owned/controlled, etc.) Yes No

6. Within the last five (5) years, has the name of the Applicant been changed or has any other business been purchased, merged or consolidated with the Applicant? If yes, provide details Yes No

7. Complete the below chart for all owners, partners, officers, directors and licensees (attach separate sheet if necessary)

Name	Title	Yrs of Ins Experience	Date First Licensed	License No.	Ownership %

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

9. Complete chart below for 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

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BOOK OF BUSINESS DETAILS

11. Complete the below production chart (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/Accident/Health Commissions	\$	\$
Other Income (Describe):	\$	\$

12. Complete the below breakdown of lines of business written based on total annual premium volume. **Total for A+B+C+D should equal 100%**

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

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

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

D. Group Life/Accident/Health & Financial Services	
If any, complete Supplemental Application	
401K's	%
Group Dental	%
Group Disability	%
Group Health (Fully-Insured)	%
Group Health (Self-Insured)	%
Group Life	%
IRA's	%
Mutual Funds*	%
Pension Plans	%
PEO's/MEWA's/MET's/VEBA's/Taft-Hartley	%
Stocks, Trade Bonds, Options, Etc.	%
Stop Loss/Reinsurance	%
Other (Explain)	%
Section D Total:	%
*If any, provide name of broker/dealer	
Overall Total (MUST EQUAL 100%)	%

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13. Does the applicant specialize in any class of risk (ie: oil/gas, contractors, auto dealers, 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 to any of the above, provide a detailed explanation

15. What percentage of the applicant's book is written as:

a. Retail (business sold directly to your insured):	%
b. Wholesale (business placed for other agents):	%
c. MGA (business for which you have underwriting authority)*	%
*If yes, complete MGA Supplement	

16. Complete the chart for your top five (5) clients:

Industry	Lines of Business	Total Premium	Total Insured Value	Highest Limit Placed

17. Complete the chart regarding your book of business:

a. Largest total insured value:	
b. Largest limits insured (including excess and umbrella):	
c. Average limits insured:	
d. Percentage of total business that is coastal?	

18. List the top 5 companies the applicant places business with on a direct basis (other than MGA's/Wholesalers)

Company Name	Date Appointed	Binding Authority?	Current AM Best Rating	Line(s) of Business	Percentage of Total Revenue
		<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			

19. Does the applicant write any policies with carriers rated less than B+ by AM Best or unrated? Yes No

a. What percentage of business is written through unrated carriers? _____ %

b. What percentage of business is written through carriers rated less than B+ by AM Best? _____ %

c. Do you have procedures in place to notify customers of such placements? Yes No

d. Do you require written acknowledgement from customers for such placements? Yes No

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20. Do you have procedures in place to notify customers of carrier downgrades? Yes No
21. Have any carrier relationships been terminated in the past five (5) years (whether by the applicant or carrier)? If Yes, provide details including reason for termination. Yes No
22. List the top five (5) surplus lines brokers and MGA's with whom the applicant places business:

SURPLUS LINES BROKER/MGA NAME	LINES PLACED	ANNUAL PREMIUM VOLUME

23. Does the applicant perform any of the following activities? If yes, advise if it is only in conjunction with insurance agent services provided to clients. (Coverage may be excluded under policy)

OPERATIONS	Yes/No	Only for Applicant's Insurance Client's?	Revenue
Risk Management/Loss Control	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Premium Finance for Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
OSHA/Environmental Studies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Reinsurance Intermediary	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Third Party Administrator (TPA)*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Claims Adjustment Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Actuarial Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Tax Preparer/Accountant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Real Estate Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

*Provide a copy of TPA Contract

PROCESSES & PROCEDURES

24. Please indicate the functions performed:

	In-House	Outside	Automated		In-House	Outside	Automated
ACCOUNTING				CLAIMS			
RATING INFORMATION				LOSS HISTORY/RUNS			
POLICY INFORMATION				MARKETING			

25. 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 disclosures of exclusions, including but not limited to Mold/Fungus and War/Terrorism?			
i. Does the applicant require insureds decline coverage offerings in writing?			
j. If the agency is an individual, is a back-up place in place for when the individual is unavailable to operate the agency's day to day operations?			

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CLAIMS INFORMATION

Provide currently valued five (5) year loss runs and a Claims Data Sheet for each claim or incident, if any. If "Yes" to any of the below questions, provide details on a separate sheet.

- 26. Have any claims or suits been made during the past five (5) 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
- 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
- 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
- 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
- 30. Has the Applicant been involved in bankruptcy proceedings? Yes No

PRIOR COVERAGE INFORMATION

31. List all professional liability, E&O or legal expense insurance carried by the applicant during the past three (3) years. If none, state "NONE". Provide a copy of expiring declarations page for proof of retroactive date.

INSURANCE COMPANY	LIMITS OF LIABILITY	DEDUCTIBLE	PREMIUM	EXPIRATION	RETRO DATE

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: _____ <div style="text-align: center;">(print name)</div>	Title: _____ <div style="text-align: center;">(print title)</div>
Signature: _____ <div style="text-align: center;">(owner, partner or senior officer)</div>	Date: _____ <div style="text-align: center;">(Month/Day/Year)</div>