



**APPLICATION FOR INSURANCE SERVICES PROFESSIONAL LIABILITY INSURANCE**

**This is an Application for a claims made and reported policy. Please read the entire Application carefully before signing. Whenever used in this Application, the term “Applicant” means the Named Insured(s) and the term “Firm” means the Named Insured(s) and any entity identified in Question 4 of this Application. Please answer all questions and attach all requested materials including the following:**

- Descriptive or promotional brochures, firm resumes, marketing materials or literature
- Resumes of all principals, partners, managing members, directors, officers, majority owners and key employees (including name, title, license held, professional designations, years of experience and years with the Applicant)
- Standard contract or engagement letter used with clients, independent contractors and subcontractors
- Latest fiscal year end and current interim financial statements for all entities proposed for coverage

**COVERAGE REQUESTED:**

Effective Date Requested: \_\_\_\_\_  
 Limits Desired:  \$1,000,000  \$2,000,000  \$3,000,000  \$5,000,000  Other \$ \_\_\_\_\_  
 Self Insured Retention (each claim):  \$5,000  \$10,000  \$25,000  \$50,000  Other \$ \_\_\_\_\_

**PROPOSED APPLICANT:**

1. Name of Applicant: \_\_\_\_\_  
 Date Established (Mo./Yr.): \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_  
 Business Website Address: \_\_\_\_\_

Individual designated to accept all notices on Applicant’s behalf: \_\_\_\_\_

Location(s) where Applicant is licensed or registered: \_\_\_\_\_

Professional organizations to which Applicant belongs: \_\_\_\_\_

2. Applicant is:  Corporation  LLC  Partnership  Other: \_\_\_\_\_  
 (a) Is the Applicant owned or controlled by, or affiliated with, any other entity?  Yes  No  
 (b) Has the name of the Applicant ever been changed?  Yes  No  
 (c) Is the Applicant a franchisee or franchisor?  Yes  No  
 (d) Are there any branch offices or additional locations?  Yes  No

**If the response to any part of Question 2 is “YES,” please attach complete details.**

3. (a) Is the Applicant a successor-in-interest to any predecessor firm or has the Applicant ever been involved in any merger, acquisition, consolidation, divestiture, bankruptcy or dissolution?  Yes  No  
 (b) In the next 12 months, does the Applicant have any plans for any merger, acquisition, consolidation, divestiture, bankruptcy, dissolution, or creation of a new business, subsidiary or division?  Yes  No

**If the response to any part of Question 3 is “YES,” please attach complete details.**

4. (a) Please provide the following information for all subsidiaries **for which coverage is desired.**

Name of Subsidiary	Location	Nature of Business	Applicant's % of Ownership
			%
			%
			%

- (b) Please provide the following information for all additional entities **for which coverage is desired.**

Name of Entity	Location	Nature of Business	Relationship to Applicant

**To enter more information for Question 4(a) and/or 4(b), please attach a separate page to the Application.**

5. Does the Applicant or any of its principals or partners own, control or manage any other entity not shown in Question 4?  Yes  No **If "YES," please attach complete details.**

**PROFESSIONAL ACTIVITIES:**

6. Please indicate the services performed by the Firm and the percentage of total commission and fee revenue derived from each service (must total 100%): **For activities in bold, please also complete the supplemental application.**

Services	Services Provided	Next 12 Months	Most Recent Fiscal Year
Agent	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Broker/Wholesaler	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
<b>MGA/MGU/Program Administrator</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Surplus Lines Broker	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Risk Manager/Loss Control	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
<b>Third Party Administrator/Claims Administrator</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Reinsurance Intermediary	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Other Services (Describe In Attachment)	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
<b>TOTAL</b>		<b>100%</b>	<b>100%</b>

7. (a) During the past 5 years or within the next 12 months, has the Firm been engaged in, or plan to engage in, any services or business activity other than those indicated in Question 6?  Yes  No  
 (b) Does the Firm provide any Professional Services over the Internet?  Yes  No  
 (c) Does the Firm provide any Professional Services outside the United States?  Yes  No

**If the response to any part of Question 7 is "YES," please attach complete details and estimated revenues.**

8. (a) Please indicate the revenue for the next 12 months and for each of the past three fiscal years.

Revenue	Next 12 Months	___ / 20___	___ / 20___	___ / 20___
P&C Commissions and Fees	\$	\$	\$	\$
Life/A&H Commissions and Fees	\$	\$	\$	\$

Total Revenue From All Other Sources Other Sources of Revenue: _____ _____	\$	\$	\$	\$
<b>TOTAL REVENUE</b>	\$	\$	\$	\$

- (b) Percentage of policies written on a direct bill basis: \_\_\_\_\_%
- (c) Percentage of policies placed with Non-Admitted carriers: \_\_\_\_\_% Total Premium: \$ \_\_\_\_\_
- (d) Percentage of policies placed through MGAs, other brokers or intermediaries: \_\_\_\_\_%
- (e) Percentage of premium volume with foreign insurance carriers: \_\_\_\_\_%
- (f) Percentage of premium volume placed through a state administered fund: \_\_\_\_\_%
- (g) Percentage of premium volume accepted from sub-producers: \_\_\_\_\_%

9. Please indicate the premium volume from the following lines of business.

Line of Business	Next 12 Months	Most Recent Fiscal Year
Standard Personal Lines	\$	\$
Sub-Standard Personal Lines	\$	\$
Individual Life/Accident Health	\$	\$
Group Life/Accident Health	\$	\$
Annuities	\$	\$
Commercial Ocean Marine	\$	\$
Trucking	\$	\$
Bonds	\$	\$
Professional Liability and D&O	\$	\$
Workers Compensation	\$	\$
Umbrella/Excess	\$	\$
Products Liability	\$	\$
Aviation	\$	\$
Crop	\$	\$
Flood	\$	\$
Wind	\$	\$
All Other Commercial P&C	\$	\$
<b>Total Premium Volume</b>	\$	\$

10. Please complete the following for **ALL** insurance carriers business was placed with in the last 12 months:

Insurance Carrier	Annual Premium Volume	Years Represented	AM Best Rating	Line of Business
	\$			
	\$			
	\$			
	\$			

**To enter more information, please attach a separate page to the application.**

11. Have any agency contracts been cancelled by any insurance carrier in the last 5 years for reasons other than lack of production?  Yes  No **If "YES," please attach complete details.**
12. During the past 5 years or within the next 12 months, has the Firm:
- (a) Been engaged in, or plan to engage in, any services or business activity other than those indicated in Question 6?  Yes  No
- (b) Placed or plan to place coverage for risks involved in petroleum and extraction, mineral exploration and mining, hazardous waste operations or operations with significant pollution exposures?  Yes  No

- (c) Placed or plan to place coverage, or been involvement with or plan to be involved with, Self-Insured/Captives, Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), Multiple Employer Trusts (MET) or Multiple Employer Welfare Arrangements (MEWA).  Yes  No
- (d) Specialized or plan to specialize in any programs or classes of business?  Yes  No

**If the response to any part of Question 12 is “YES,” please attach complete details and financial data.**

13. During the past 5 years or within the next 12 months, has any principal, partner, managing member, director, officer, professional employee, leased employee or independent contractor of the Firm been engaged to provide, or plan to provide, professional services for or in connection with any entity in which he, she, the Applicant, or any other proposed insured had/has an ownership or financial interest?  
 Yes  No **If “YES,” please attach complete details.**

**REGISTERED REPRESENTATIVE COVERAGE:**  Yes (Answer Question 14)  No

14. (a) Please indicate the Commissions derived during the past 12 months from the following:
- |                    |          |                  |          |
|--------------------|----------|------------------|----------|
| Variable Life      | \$ _____ | Stocks and Bonds | \$ _____ |
| Variable Annuities | \$ _____ | Pension Plans    | \$ _____ |
| Mutual Funds       | \$ _____ | 401-K Plans      | \$ _____ |
- (b) Name of Broker/Dealer: \_\_\_\_\_
- (c) Number of employees with: Series 6 license: \_\_\_\_\_ Series 7 license: \_\_\_\_\_
- (d) Have there been any U-4 or U-5 violations in the past 5 years?  Yes  No **If “YES,” please attach complete details.**

**TRAINING AND RISK MANAGEMENT:**

15. (a) Please indicate the following information for all licensed employees/independent contractors and Customer Service Representatives (CSRs) of the Firm:

	Total Number	Average Years of Experience	Average Years With Applicant	Turnover Rate Last 3 Years		
				20__ 20__ 20__	%	%
Licensed Agents/Brokers				___%	___%	___%
CSRs				___%	___%	___%

- (b) How many of the licensed Agents/Brokers are independent contractors? \_\_\_\_\_.
- (c) Is coverage desired for independent contractors?  Yes  No  Not Applicable **If “NO,”** are independent contractors required to maintain their own E&O insurance?  Yes  No **If “YES,”** minimum limits required: \$ \_\_\_\_\_
16. Does the Firm have:
- (a) Written procedures to escalate complaints to senior management?  Yes  No
  - (b) Written risk management procedures in place including written procedures to ensure compliance with all federal, state and local statutes and regulations?  Yes  No
  - (c) A formal training program for personnel?  Yes  No
  - (d) Network security management procedures to prevent breaches of security including identity theft and the spread of computer viruses?  Yes  No
  - (e) Written procedures in place to protect, or provide training for the protection of, the personal and confidential information of clients and prospective clients?  Yes  No
  - (f) Legal/Clearance procedures for media and marketing material and content?  Yes  No
  - (g) Internal Control procedures to prevent theft of client funds or other client assets?  Yes  No
17. Does the Firm:
- (a) Use a centralized diary or suspense system?  Yes  No
  - (b) Date stamp all incoming mail?  Yes  No
  - (c) Use a pre-printed form for documenting business telephone conversations?  Yes  No
  - (d) Have standardized file construction procedures?  Yes  No

- (e) Use coverage checklists for both commercial and personal lines clients?  Yes  No
- (f) Have procedures in place to address terrorism and mold exposures with each client?  Yes  No
- (g) Obtain client signatures confirming their understanding when terrorism and/or mold coverage is not provided?  Yes  No
- (h) Document client refusals to accept coverage or limit recommendations?  Yes  No
- (i) Provide clients with written confirmation of reductions in current/proposed coverage?  Yes  No
- (j) Confirm all binders promptly in writing?  Yes  No
- (k) Maintain a policy expiration list (including Direct Bill)  Yes  No
- (l) Check all applications, policies and endorsements for accuracy prior to mailing?  Yes  No
- (m) Mark files to ensure certificate holders are notified of cancellation/material change?  Yes  No
- (n) Retain records for a minimum of 5 years?  Yes  No
- (o) Ensure credit checks/investigations comply with the Fair Credit Reporting Act?  Yes  No

18. (a) If the Firm accepts business from sub-producers, are sub-producers required to carry E&O Insurance?  Yes  No  Not Applicable If "YES," minimum limits required: \$ \_\_\_\_\_
- (b) If the Firm places business through MGAs, wholesalers or other intermediaries, are they required to carry E&O insurance?  Yes  No  Not Applicable If "YES," minimum limits required: \$ \_\_\_\_\_

**PRIOR INSURANCE:**

19. List all professional liability insurance carried for each of the past three years. If none, the reason for the present insurance inquiry is: \_\_\_\_\_

Insurance Company	Limits	Retention	Premium	Policy Period
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	

Retroactive Date on current policy: \_\_\_\_\_

Prior and Pending Litigation Date on current policy or, if none, Date of first E&O policy: \_\_\_\_\_

20. Has the Applicant had any Professional Liability Insurance declined, cancelled or non-renewed within the past three years?  Yes  No **If "YES," please attach complete details.**

**CLAIMS EXPERIENCE:**

21. Have any claims, suits or proceedings (including without limitation: any shareholder action or derivative suit; or any civil, criminal, or regulatory action, or any complaint, investigation or proceeding related thereto) been made during the past five years against: (a) the Applicant; (b) its predecessors in business; (c) any subsidiary or affiliate of the Applicant; (d) any other entity proposed for coverage; or (e) any past or present principal, partner, managing member, director, officer, employee, leased employee or independent contractor of the Applicant, its predecessors in business, any subsidiary or affiliate of the Applicant or any other entity proposed for coverage?  Yes  No
22. Is the Applicant (after diligent inquiry of each principal, partner, managing member, director or officer) aware of any fact, circumstance, incident, situation, or accident (including without limitation: any shareholder action or derivative suit; or any civil, criminal, or regulatory action, or any complaint, investigation or proceeding related thereto) that may result in a claim being made against: (a) the Applicant; (b) its predecessors in business; (c) any subsidiary or affiliate of the Applicant; (d) any other entity proposed for coverage; or (e) any past or present principal, partner, managing member, director, officer, employee, leased employee or independent contractor of the Applicant, its predecessors in business, any subsidiary or affiliate of the Applicant or any other entity proposed for coverage?  Yes  No

23. Has the Applicant or any individual or entity proposed for coverage ever been the subject of a reprimand, or a disciplinary or criminal action by any federal, state or local authority, professional association or state licensing board?  Yes  No
24. Has the Applicant or any individual or entity proposed for coverage been involved during the past five years in any disputes with respect to fees or other compensation which may be due for professional services rendered by the Applicant, any subsidiary or affiliate of the Applicant, or any other entity proposed for coverage?  Yes  No
25. Is the Applicant or any individual or entity proposed for coverage aware of any actual or alleged deficiencies, errors or omissions in work performed by the Applicant, any subsidiary or affiliate of the Applicant, any other entity proposed for coverage, or by others for whom the Applicant is legally responsible?  Yes  No

**If the response to Question Questions 21, 22, 23, 24, and/or 25 is “YES,” please attach complete details.**

**NOTE: It is agreed that any claim or lawsuit against the Applicant, or any principal, partner, managing member, director, officer or employee of the Applicant, or any other proposed insured, arising from any fact, circumstance, act, error or omission disclosed or required to be disclosed in response to Questions 21, 22, 23, 24, and/or 25, is hereby expressly excluded from coverage under the proposed insurance policy.**

26. Has the Applicant reported the matters listed in Questions 21-25 to its current or former insurance carrier?  
 Yes  No  Not Applicable

**Supplement app below – please indicate if applicable.**

**SUPPLEMENTAL APPLICATION FOR MANAGING GENERAL AGENTS, MANAGING GENERAL UNDERWRITERS AND PROGRAM ADMINISTRATORS, AND THIRD PARTY ADMINISTRATORS AND CLAIM ADMINISTRATORS**

Please read this entire Supplemental Application carefully before signing. Whenever used in this Supplemental Application, the term "Applicant" means the Named Insured(s) and the term "Firm" means the Named Insured(s) and any other entity proposed for coverage. Please also attach the following:

- Sample Contract of Engagement

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

MGA/MGU/PROGRAM ADMINISTRATORS COVERAGE:  Yes (Answer Questions 1-6)  No

1. (a) The Firm is a Managing General Agent (MGA), Managing General Underwriter or a Program Administrator for the following carriers:

Carrier	Lines of Insurance	Number of Years	Annual Gross Premium Volume	Loss Ratio Last 3 Years 20__ 20__ 20__
			\$	___% ___% ___%
			\$	___% ___% ___%
			\$	___% ___% ___%
			\$	___% ___% ___%

**To enter more information, please attach a separate page.**

(b) How often are audits performed by the carriers? \_\_\_\_\_

(c) Recommendations/Criticisms made as a result of audits over the past 3 years: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(d) Steps taken to address Recommendations/Criticisms: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Describe ALL programs that were terminated or moved to another carrier during the last 5 years and the reason for the termination/move: \_\_\_\_\_  
 \_\_\_\_\_

3. Please list all functions performed as an MGA, MGU or Program Administrator:

Quoting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum limit of authority:
Underwriting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum limit of authority:
Binding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum limit of authority:
Policy Issuance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Claims Adjusting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum limit of authority:
Claims Administration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe:
Actuarial Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Loss Control	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reinsurance Placement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Facultative: ___% Treaty: ___%

4. Please indicate:
- (a) Number of policies issued annually: \_\_\_\_\_.
  - (b) Number of producers business is received from: \_\_\_\_\_.
  - (c) Number of producers with binding authority: \_\_\_\_\_ Premium Volume: \$ \_\_\_\_\_
  - (d) What checks/supervision you exercise over sub-producers: \_\_\_\_\_
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5. Describe the procedures used to ensure adherence to client’s quoting, underwriting, binding, claims adjusting/administration and other procedures: \_\_\_\_\_

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6. Describe the procedures to select sub-producers: \_\_\_\_\_

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**TPA/CLAIM ADMINISTRATORS COVERAGE:**  Yes (Answer Questions 7-11)  No

7. Please indicate the percentage of the total annual revenue for each of the following:

Insurance Company Claims Adjusting	%
Self Insured/RRG Claims Adjusting	%
Reinsurance Claims Adjusting	%
Public Adjusting	%
Utilization Reviews	%
Medical Bill Review/Cost Containment	%
Other:	%

8. Please indicate the following for the top 5 clients:

Client	Description of Services	Revenues Last 12 Months
		\$
		\$
		\$
		\$
		\$

9. Does the Firm have:
- (a) Draft authority?  Yes  No **If “YES,”** the amount is: \$ \_\_\_\_\_
  - (b) Its authority and/or limitations by clients defined in writing?  Yes  No
  - (c) A fee collection process to minimize the need to file suit to collect fees?  Yes  No
  - (d) Medical doctors/nurses on staff?  Yes  No **If “YES,” please attach details regarding their role.**

10. Does the Firm:
- (a) Refer others to healthcare providers or healthcare provider networks for medical evaluations?  
 Yes  No **If “YES,”** please attach procedures for credentialing healthcare providers or selecting healthcare provider networks.
  - (b) Contract with healthcare providers or healthcare provider networks to provide medical care to others?  
 Yes  No **If “YES,”** please attach procedures for credentialing healthcare providers or selecting healthcare provider networks.
  - (c) Refer others to third parties who provide repair, restoration, remediation, construction or other services or products?  Yes  No **If “YES,”** please attach procedures for selecting those third parties.
  - (d) Have the authority to deny medical services because of medical necessity?  Yes  No **If “YES,”** please attach utilization review/management procedures and resumes for all personnel who have authority

to deny medical services because of medical necessity.

(e) Contract with third parties who have the authority to deny medical services because of medical necessity?  Yes  No **If “YES,”** please attached procedures for selecting those third parties.

11. Does the Firm have:

(a) HIPAA compliance policies and procedures?  Yes  No **If “YES,”** please attach a copy of the procedures. **If “NO,”** please attach an explanation.

(b) Other regulatory compliance policies and procedures which regulate how the Firm performs professional services?  Yes  No **If “YES,”** please attach a copy of the procedures.

(c) Claim file audit procedures?  Yes  No **If “YES,”** please attach a copy of the procedures.

(d) Procedures to ensure that claim payments are calculated accurately and within the Firm’s authority and are paid in a timely manner?  Yes  No **If “YES,”** please attach a copy of the procedures.

(e) Procedures to ensure that clients report claims to the Firm and the Firm reports claims to insurers or other payors in a timely manner?  Yes  No **If “YES,”** please attach a copy of the procedures.

(f) Procedures to comply with other client procedures?  Yes  No

**NOTICE – PLEASE READ CAREFULLY**

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after diligent inquiry of each principal, partner, managing member, director, officer and employee of the Firm, the statements in this Application are true and complete and will be relied upon by the Insurer in issuing any policy. The undersigned agrees that if the information provided in this Application changes between the time this Application is executed and the time the proposed insurance policy is bound or coverage is commenced, the Applicant will immediately notify the Insurer in writing of such changes, and that the Insurer may withdraw or modify any outstanding quotations or agreements to bind the insurance. The undersigned hereby authorizes the Insurer to make any inquiry in connection with the information, statements and disclosures provided in this Application and further authorizes the release of claim information from any prior insurer to the Insurer.

The undersigned declares that all individuals and entities proposed for this insurance understand and accept that the policy applied for provides coverage for only those claims that are first made against the Insured and reported in writing to the Insurer during the policy period or any extended reporting period (if applicable) and that the limits of liability contained in the policy will include both Damages and Claim Expenses.

The signing of this Application does not bind the Insurer to offer nor the undersigned to purchase the insurance, but it is agreed this Application shall be the basis of the insurance and shall be considered physically attached to and become part of the Policy should a Policy be bound and issued. All attachments and information submitted to or obtained by the Insurer in connection with this Application are hereby incorporated by reference into this Application and made a part hereof.

**The Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.**

\_\_\_\_\_  
Date (Mo./Day/Yr.)

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Print or Type Name

\_\_\_\_\_  
Title