



www.CoverX.com

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IMPORTANT – To be completed by Producer:

Name: _____

Producer Is: Wholesaler Retailer

Address: _____

Telephone: _____

Fax: _____

Email: _____

Proposed Effective Date: _____

If Renewal, Provide Current Policy No.: _____

IMPORTANT – To be completed by Producer who will handle the Surplus Lines transaction(s):

Resident or Non-Resident Surplus Lines Licensee Information for Applicant’s State of Domicile:

SL Licensee Agency Name: _____

SL License State: _____

SL License No.: _____

SL License Expiration Date: _____

SL Licensee Name (if not an Entity License): _____

Affiliation with Producer (e.g., Owner, Executive Officer, Employee): _____

LIMITS OF PROFESSIONAL LIABILITY INSURANCE REQUESTED

\$1,000,000 \$2,000,000 \$3,000,000 \$4,000,000 \$5,000,000

DEDUCTIBLE LIMIT REQUESTED

\$5,000 \$10,000 \$15,000 \$20,000 \$25,000 Other: _____

Miscellaneous Professional Liability Insurance Application

Instructions to the Applicant:

1. Please answer all questions completely. Your answers will be used to make important underwriting and pricing decisions and are considered legally material to all decisions made by us.
2. The application and any supplemental documents must be signed and dated by an authorized person of the prospective Applicant to be insured.
3. Please attach any marketing brochures or advertising materials used in the operations of your company.
4. Please attach your most recent financial statements.
5. Please attach a copy of your standard contract and any other materials used to outline the services you provide to your clients and your contractual obligations.

Important to Note: This is an application for a Claims Made and Reported policy. It will apply only to claims first made during the policy period and reported to us within 60 days after the expiration of the policy period or during any applicable extended reporting period. Claims expenses are included within the limits of liability and deductible amount. The Company shall not be liable for any Defense Costs or the amount of any settlement or judgments or pay any damages upon the exhaustion of the applicable limit.

GENERAL INFORMATION:

1. Applicant's Legal Name: _____
2. Street Address: _____
Mailing Address (if different than above): _____
3. Website Address: _____
4. Name of contact person: _____ Telephone No.: _____
5. Individual Corporation Partnership Privately Held Not-For-Profit Publicly Traded
 Other (Describe): _____
6. Date Established: _____ SIC Code: _____
7. During the past 5 years has the name of the Applicant changed, or has any other business been acquired, merged into or consolidated with the Applicant? YES NO
If Yes, please explain, including dates acquired and liabilities assumed: _____

8. Is the Applicant owned, controlled, affiliated, or associated with any other entity? YES NO
If Yes, please explain: _____

 - a. Names and locations of all subsidiaries or affiliates:

 - b. If coverage is desired for all entities listed above? YES NO
If No, please specify which entities will not be included:

 - c. Are any professional services provided by the Applicant to any owned, controlled, affiliated or associated entity? YES NO
If Yes, please explain and indicate percent % of total revenues derived from this entity(ies): _____

9. Are any significant changes in the nature or size of the Applicant expected over the next 12 months? YES NO
If Yes, please explain: _____

INSURANCE HISTORY:

10. Please provide the following information as respects prior professional liability or errors and omissions insurance coverage during the last 3 years: (If occurrence coverage, please indicate under retro date.)

Insurance Company	Policy Term	Limit of Insurance	Deductible Amount	Retro Dates	Premium

11. If commercial general liability coverage is maintained, please indicate as follows:

Insurance Company	Policy Term	Insurance Limit	Premium

Does the general liability policy contain:

Products/Completed Operations Coverage? YES NO

Personal Injury/Advertising Injury Coverage? YES NO

12. Has any insurance ever been cancelled or declined? YES NO

If Yes, please explain: _____

(Note: Applicants in Missouri are not required to answer this question.)

PROFESSIONAL SERVICES:

13. Please provide a description of professional services provided and which the Applicant wishes to be covered by this insurance. Be specific, as this description will be used to describe the professional liability coverage in the policy.

Description of Services	% of Gross Revenues

a. Please indicate any revenues in the past 3 years that you have collected outside of the U.S and its territories:

14. Please describe the types of potential professional liability exposures that could result in a claim due to an error or omission arising out of the services you provide:

15. Total gross revenues: This year: \$ _____ (Estimated)
 Last year: \$ _____
 Year prior: \$ _____

16. Please indicate the Applicant's 5 largest jobs/clients in the last 3 years:

Client	Professional Services Provided	Total Contract Cost
		\$
		\$
		\$
		\$

17. Provide the following staffing numbers: Partners or Officers: _____
 Full-Time Professional Staff: _____
 Part-Time Professional Staff: _____
 Support Staff: _____

18. Does the Applicant subcontract professional services to others? YES NO
 If yes, please explain type of services subcontracted and percent of total revenue subcontracted:

a. Does the Applicant require certificates of insurance for professional services subcontracted? YES NO
 If Yes, please state minimum limits of insurance required:

b. Is the Applicant held harmless contractually for the acts, errors or omissions of the subcontractor? YES NO
 If No, please explain:_____

19. Do you use written contracts or agreements describing the scope of your services? YES NO

a. If Yes, what percentage of the time do you use these contracts?_____

b. If Yes, do your contracts contain the following:

Hold Harmless clauses that release you from liability? YES NO

Hold Harmless clauses that release any other party from liability? YES NO

Warranties or Guarantees for the services you provide? YES NO

Disclaimers? YES NO

c. If you do not use contracts all of the time, please explain how you outline the scope of your services to clients and the responsibilities and rights of all parties involved:_____

20. Please list the professional qualifications of the principals and key employees:

Name	Professional Memberships/Designations	Years in Profession	Years with Applicant

CLAIMS HISTORY:

21. Is the Applicant aware of any fact or circumstance which may reasonably be expected to lead to a claim or potential claim against you or any other person past or present in your organization? YES NO If yes, please explain (Include names of potential claimants, nature of allegations, dates services were provided and amount demanded):

22. Please indicate the name of the Applicant's law firm or general counsel used for contractual issues, claims issues, and dispute Resolutions:

23. Have you or any past or present person within your organization ever been subject to any disciplinary actions or regulatory Investigations? Please explain:_____

24. Please list all professional liability claims from the past 5 years as indicated:

DATE OF CLAIM	DESCRIPTION OF CLAIM	PAID LOSS	PAID EXPENSE	AMOUNT OUTSTANDING/RESERVED	OPEN (O) OR CLOSED (C) CLAIM

Please list any additional information below:

It is agreed and understood that any policy issued shall not provide coverage for any claim, fact, or action arising from any alleged act, error or omission which may be afforded insurance or is now known by any person(s) or entity(ies) of the Applicant. This exclusion from coverage set forth in the prior sentence includes any claim, fact or action under a policy currently in force whether or not disclosed in this application.

State Notices: The following notices are required by the Insurance Department of the indicated states.

WARNING: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

NOTICE TO ARKANSAS APPLICANTS: 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.

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

NOTICE TO COLORADO APPLICANTS: 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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: 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 denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: 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 civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO TENNESSEE APPLICANTS: 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.

NOTICE TO VIRGINIA APPLICANTS: 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.

NOTICE TO WASHINGTON APPLICANTS: 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.

NOTICE TO WEST VIRGINIA APPLICANTS: 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.

THE UNDERSIGNED DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE INSURANCE, NOR DOES REVIEW OF THE APPLICATION BIND THE INSUROR TO ISSUE A POLICY. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

SIGNED BY:

Applicant

Date

Producer

Date

NOTICE:

- 1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED “NONADMITTED” OR “SURPLUS LINE” INSURERS.**
- 2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.**
- 3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.**
- 4. CALIFORNIA MAINTAINS A LIST OF ELIGIBLE SURPLUS LINE INSURERS APPROVED BY THE INSURANCE COMMISSIONER. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE:www.insurance.ca.gov.**
- 5. FOR ADDITIONAL INFORMATION ABOUT THE INSURER YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR “SURPLUS LINE” BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE, AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER: 1-800-927-4357.**
- 6. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER’S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.**

Date: _____
Insured: _____