



Apogee Insurance Group LLC
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PROFESSIONAL LIABILITY APPLICATION

IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS-MADE BASIS

NOTICE: THE POLICY PROVIDES THAT THE LIMIT OF LIABILITY TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE. FURTHER NOTE THAT AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.

1. NAME OF APPLICANT: _____

ADDRESS: _____

ADDRESS OF BRANCHES: _____

TELEPHONE NO.: () _____

2. LIMIT OF LIABILITY DESIRED:

\$100,000 ____ \$300,000 ____ \$500,000 ____ \$1,000,000 ____ Other _____

3. DEDUCTIBLE:

\$1,000 ____ \$2,500 ____ \$5,000 ____ \$10,000 ____ Other _____

4. Please describe in detail the professional activities for which coverage is desired:

5. Is the applicant engaged in any business or profession other than as described in Item 4? _____
If yes, please attach an explanation and estimated receipts.

6. List the total gross receipts for the past three years derived from those activities in Question 4. In addition, please list projected receipts for the current policy year.

Fees & Receipts estimated for new policy year: _____

Actual Fees & receipts for past three years: 20 _____

20 _____ 20 _____

7. For the receipts listed in question 6), please give the approximate percentage derived from each of the activities listed in Question 4-

ACTIVITY	% OF 6) RECEIPTS
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %

8. Applicant is: Corporation _____ Partnership _____ Individual _____

9. Year Established: _____

During the past 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 particulars: _____

10. Is the Applicant Firm controlled, owned or associated with any other firm, corporation or company? _____ Yes _____ No. If yes, attach an explanation. Are any activities listed in Question 4 provided to such business enterprise? _____ Yes _____ No

11. a) Number of principals, partners, officers and professional employees directly engaged in providing services to clients: _____

b) Number of non-professional employees (clerks, secretaries, etc.)- _____

12. Please provide the following:

Name in full of ALL Partners/ Principals/Key Employees.	PROFESSIONAL QUALIFICATIONS	DATE QUALIFIED	HOW LONG IN PRACTICE	HOW LONG AS PARTNER/PRINCIPAL
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

13. To what professional association(s) does the applicant firm belong?

14. Please include a list of Applicant Firm's five (5) largest jobs or projects during the past three (3) years. Please give, in detail: 1) project/name; 2) the nature of the services performed for the client; and 3) the revenues obtained from those services.

15. Does the Applicant Firm use a written contract with clients?

_____ In all cases _____ Sometimes _____ Never

Please attach a copy of your standard contract.

16. What percentage of the Applicant Firm's business involves subcontracting of work to others? _____% Does the Applicant Firm provide professional services to business entities in which it retains an ownership interest? Yes _____ No _____ If Yes, please explain.

17. Has any similar insurance ever been declined or canceled? Yes _____ (if Yes, attach explanation.)
No _____

18. List errors and omissions insurance carried for each of the past THREE years. If none, state NONE.

Inception	Expiration	Insurance Company	Premium	Limits of liability	Deductible
From ___/___/19__ to ___/___/20__		_____	_____	_____	_____
From ___/___/20__ to ___/___/20__		_____	_____	_____	_____
From ___/___/20__ to ___/___/20__		_____	_____	_____	_____

If "Retroactive Date" prior to policy inception is requested, please advise date: _____

19. **ATTACH COPIES OF:**

- advertisements, brochures, descriptive literature**
- sample contract between you and your clients outlining services to be rendered**
- latest financial data (Annual Report or balance sheet)**

20. Have any of the individuals listed in Question No. 12 ever been the subject of disciplinary action by authorities or professional organizations as a result of their professional activities? If Yes, please explain.

- 21. Does any person to be Insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him?
Yes _____ No _____ (If Yes, attach full particulars).
- 22. Attach a list and status of all errors and omissions claims made against any proposed Insured(s) during the past three years. If None, please check here: NONE _____
- 23. It is agreed with respect to questions #20, 21 and 22 above, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND MADE A PART OF THE POLICY. THE UNDERSIGNED APPLICANT DECLARES THAT TO THE BEST OF HIS KNOWLEDGE THE STATEMENTS SET FORTH IN THIS APPLICATION ARE TRUE. THE APPLICANT FURTHER DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE TIME WHEN THE POLICY IS ISSUED, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGE.

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 CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY AND SIGN BELOW WHERE INDICATED. IF A POLICY IS ISSUED, NEW YORK INSURANCE DEPARTMENT REGULATIONS REQUIRE THAT THIS SIGNED STATEMENT BE ATTACHED TO THE POLICY.

The Insured hereby acknowledges that he/she/it is aware that the limit of liability contained in this policy shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limits of liability of this policy.

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.

The Insured hereby further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

PRODUCER: _____

INSURED: _____

ADDRESS: _____

BY: _____

TITLE: _____

DATE: _____

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: _____

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

Signature of Applicant _____ Date _____

6. Please indicate any of the following that you provide to your customers:

- Protein diet plans Body wraps--other than organic
 Stress testing Weight loss or diet clinics

7. Premises exposures:

Hours of operation from _____ to _____

- Is parking lot well lit? Yes No
 Shower/sauna/steam or Jacuzzi facilities? Yes No
 Do the floors for these areas have non-skid surfaces? Yes No
 Any trampolines? Yes No
 Any electrode machines? Yes No

8.	Number of Employees	Employed	Leased	Independent
	Certified aerobic instructors			
	Uncertified aerobic instructors			
	Personal trainers			
	Masseuses			
	Other (describe)			
	Total number of employees			
	Number of employees trained in CPR			

- Do independents provide you with certificates of insurance? Yes No
 Are you included as an additional insured? Yes No

Producer's Signature: _____ Date: _____

Applicant's Signature: _____ Date: _____

Agent Name: _____ Agent License Number: _____