

MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION

NOTICE: IF A POLICY IS ISSUED:

- A. IT WILL BE ON A CLAIMS MADE AND REPORTED BASIS APPLYING ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE COMPANY WHILE THE POLICY IS IN FORCE, DURING THE AUTOMATIC EXTENDED REPORTING PERIOD, OR THE EXTENDED REPORTING PERIOD, IF PURCHASED;**
- B. THE LIMITS OF LIABILITY AVAILABLE UNDER THE POLICY TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR CLAIM EXPENSES. FURTHER, SUCH AMOUNTS INCURRED FOR CLAIM EXPENSES SHALL BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.**

INSTRUCTIONS FOR THE COMPLETION OF THIS APPLICATION

- 1. Please read application carefully and answer all questions thoroughly.
- 2. Attach separate pages with additional information in answer to any question for which the provided space is not sufficient.
- 3. Sign and date application. Policy cannot be bound without the appropriate signature and date.
- 4. Please provide the following additional required underwriting information:
 - A. latest completed fiscal year-end CPA audited, reviewed or compiled financial statements or latest federal income tax return filed;
 - B. current resumes of the "Applicant" and any and all of the "Applicant's" principals, partners and key professional employees;
 - C. complete copies of all standard contracts used by the "Applicant" with its clients, independent contractors or subcontractors;
 - D. copies of all promotional and advertising copy used by the "Applicant" to market its services or products;
 - E. copies of any professional licenses or certificates held by any of the "Applicant's" principals, partners or employees.

DEFINITIONS: The following terms appear in this application and are defined as follows (**Please note that the following defined terms shall not be construed as the definition of a "Claim" or an "Insured" as used in the policy**):

A. PROFESSIONAL LIABILITY CLAIM means:

- 1. a written or oral demand, service of suit or institution of arbitration proceedings received by a PROSPECTIVE INSURED seeking damages or relief of any kind, including but not limited to any kind of monetary or compensatory damages, injunctive or declaratory relief, retribution of any kind, non-pecuniary relief of any kind, or any corrective action(s) for any act(s) or omission(s) actually or allegedly committed by a PROSPECTIVE INSURED, in the PROSPECTIVE INSURED'S rendering of services of any nature or supplying of products to others;

B. PROSPECTIVE INSURED means:

1. the "Applicant" or any past or present officer, director, partner, employee, independent contractor, or subcontractor of the "Applicant," in the capacity of such or in any other capacity.

1.a. Name of "Applicant": _____

DBA: _____

(NOTE: Whenever used, "Applicant" means the entity(ies) shown in 1.a. and 1.c.)

Street Address: _____
(Street Number) (Street) (Suite or Floor Number)

(City) (State) (Zip)

Mailing Address (if different from above):

(Street Number) (Street) (Suite or Floor Number)

(City) (State) (Zip)

Telephone Number (_____) _____ Fax Number (_____) _____

(Please list all other addresses of office locations occupied by the Insured on a separate sheet of paper.)

- 1.b. Is the "Applicant" (check one): Individual/Sole Proprietorship Partnership
 Corporation LLC LLP
 Other (please provide details) _____

- 1.c. If coverage is desired for any entities other than those shown in 1.a. (i.e. subsidiaries, joint ventures, or partnerships), please list each such entity below or on a separate sheet, if required:

Name and Address	Relationship to "Applicant"	Description of Operations	Percent Owned
_____	_____	_____	_____
_____	_____	_____	_____

- 2.a. Is the "Applicant" controlled, owned by, employed by, or associated with any other entity not shown in 1.c. above? Yes No

- 2.b. Does any PROSPECTIVE INSURED control or own any other entity not shown in 1.c. above? Yes No

(If the answer to 2.a. or 2.b. is "Yes," please provide complete details on a separate sheet of paper.)

3.a. Date "Applicant" was established: _____

3.b. Date first services were offered by the "Applicant": _____

3.c. Date first products were offered by the "Applicant": _____

4. Please describe in detail the professional activities or services for which coverage is desired (Note: If a policy is issued, it may not cover all of the activities or services described.):

5.a. Please describe in detail all other professional activities or services conducted by the "Applicant" for which **coverage is not desired**:

5.b. Gross Annual current fiscal year revenues* derived from such other activities/services for which **coverage is not desired**:

\$ _____ (*Please project and annualize)

6. Please list the gross revenues for the fiscal years indicated from all activities and/or services conducted by the "Applicant":

	Date of Fiscal Year End	Gross Revenues
Current fiscal Year* (*Please project & annualize gross revenues)	___ / ___ / ___	\$ _____
Latest Fiscal Year ended	___ / ___ / ___	\$ _____
Prior Fiscal Year ended	___ / ___ / ___	\$ _____

7. Are any of the "Applicant's" directors, officers, partners or employees personally engaged to provide professional services for or on behalf of any entity other than the "Applicant"?

Yes No

(If "Yes," please provide complete details on a separate sheet of paper.)

8.a. Please indicate the number of directors, officers, partners and employees engaged in providing services to the "Applicant's" clients: _____

8.b. Please indicate the number of all other (non-professional/clerkical) employees: _____

8.c. Please provide the following information:

Name and Title of all Directors, Officers, Partners and Key Employees	Professional Qualifications/ Designations	Date Qualified/ Licensed	Number of Years in Practice	Number of Years with the "Applicant"
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9.a. Has any PROSPECTIVE INSURED ever been subject to a disciplinary action, including, but not limited to, a reprimand, reproof or censure, by any regulatory body, peer review board or committee or any professional association? Yes No

(If "Yes," please attach complete details.)

9.b. Has any PROSPECTIVE INSURED ever been convicted of a felony? Yes No

(If "Yes," please attach complete details.)

9.c. Has any PROSPECTIVE INSURED ever had his, her or its license or privilege to render professional services of any nature revoked or suspended? Yes No

(If "Yes," please attach complete details.)

10. Please provide the following with respect to the "Applicant's" top five revenue-producing clients or projects during the latest fiscal year end:

Name of Client/Project	Services Provided for Client/Project	Annual Revenues Derived from Client/Project
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11.a. Does the "Applicant" enter into written contracts with its clients? Please check one of the following: In all cases Sometimes Never

11.b. If the "Applicant" checked "Sometimes" or "Never," please describe in detail the procedures which the "Applicant" follows to ensure that the terms and conditions by which the "Applicant" provides Professional Services to its clients are mutually agreed upon and understood when a written contract does not exist:

12.a. Has the "Applicant" ever engaged or will the "Applicant" ever engage subcontractors? Yes No

(If "Yes," please provide responses to 12.b. and 12.c.)

12.b. What is the percentage of the latest fiscal year ended gross revenues that are attributable to services performed by subcontractors? _____ %

12.c. Please describe the circumstances when subcontractors have been or will be engaged:

13.a. Does the "Applicant" have Professional Liability Insurance currently in force? Yes No

13.b. If "Yes," please provide the following information for the current and prior two policy periods:

Name of Insurer	Limits	Deductible	Premium	Policy Period	Retroactive Date (if any)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

13.c. Is such coverage written on a claims-made or occurrence basis? Claims-made Occurrence

13.d. Has the "Applicant" ever purchased extended discovery or extended reporting period coverage from any current or prior Professional Liability insurer? Yes No

(If "Yes," please attach details.)

13.e. With respect to any Professional Liability Insurance coverage currently in force, or that was ever previously in force, which covers or covered any PROSPECTIVE INSURED, has any insurer:

1. Declined to offer terms or refused renewal? Yes No

2. Imposed special conditions to the coverage? Yes No

(If "Yes," please provide details on a separate sheet of paper.)

14.a. Have any PROFESSIONAL LIABILITY CLAIMS been made against any PROSPECTIVE INSURED during the past six years? Yes* No

14.b. Does any PROSPECTIVE INSURED have knowledge or information of any circumstance or any allegations or contentions or any incident which may result in any PROFESSIONAL LIABILITY CLAIM being made against any PROSPECTIVE INSURED? Yes* No

*NOTE: If 14.a. or 14.b. are answered "Yes," please complete and attach a Claims Supplement form for each such PROFESSIONAL LIABILITY CLAIM, circumstance, allegation or contention, or incident.

It is agreed that any PROFESSIONAL LIABILITY CLAIMS made prior to the inception of the policy, or any future PROFESSIONAL LIABILITY CLAIMS resulting from any circumstances or any allegations or contentions of any incident of which any PROSPECTIVE INSURED has knowledge or information prior to the inception of the policy, are excluded from the coverage sought by the "Applicant" from the Company.

15.a. Limits of Liability requested:

- | | |
|--|--|
| <input type="checkbox"/> \$500,000/\$500,000 | <input type="checkbox"/> \$2,000,000/\$2,000,000 |
| <input type="checkbox"/> \$500,000/\$1,000,000 | <input type="checkbox"/> \$3,000,000/\$3,000,000 |
| <input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$4,000,000/\$4,000,000 |
| <input type="checkbox"/> \$1,000,000/\$2,000,000 | <input type="checkbox"/> \$5,000,000/\$5,000,000 |
| <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> OTHER _____ |

15.b. Deductible requested:

- | | | | |
|-----------------------------------|-----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$20,000 |
| <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$50,000 | <input type="checkbox"/> \$75,000 | <input type="checkbox"/> \$100,000 |

Other (Please specify \$ _____)

16. The officer of the Firm designated to receive any and all notices from the Company or its authorized representative(s) concerning this insurance is: (Give name and full official title)

Name _____ Title _____

17. Please provide the following information concerning the "Applicant's" general liability insurance currently in force:

Name of Insurer: _____

THIRD PARTY ADMINISTRATORS SUPPLEMENT

1. Name of Applicant: _____

2. Please provide the percentage of gross annual revenues derived from the performance of claims administration/adjusting services for the following lines of insurance or benefit plans:

	<u>Current Fiscal Year*</u>	<u>Latest Fiscal Year Ended</u>
a. Individual accident and health	_____	_____
b. Personal lines	_____	_____
c. Workers Compensation	_____	_____
d. Commercial Auto	_____	_____
e. Commercial Property	_____	_____
f. Commercial Liability	_____	_____
g. Professional Liability	_____	_____
h. Group health and welfare plans or trusts	_____	_____
i. Other (please detail)	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(*Projected and annualized)

3. With respect to claims administration/adjusting services performed for the lines of insurance or benefit plans accounting for 10% or more of the Applicants current fiscal year or latest fiscal year end gross annual revenues, please list all insurance carriers underwriting such lines of insurance or which provide benefits under such benefit plans:

4. Has the Applicant or any entity under common ownership or control as the Applicant or any of its directors or officers performed any of the following services, or anticipate performing the following services in the next twelve months?

	Yes	No
a. Risk management consulting	<input type="checkbox"/>	<input type="checkbox"/>
b. Loss control, OSHA or loss prevention consulting	<input type="checkbox"/>	<input type="checkbox"/>
c. Safety inspections	<input type="checkbox"/>	<input type="checkbox"/>
d. Insurance sales or placement	<input type="checkbox"/>	<input type="checkbox"/>
e. Reinsurance placement or consulting	<input type="checkbox"/>	<input type="checkbox"/>

- | | Yes | No |
|---|--------------------------|--------------------------|
| f. Premium financing | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Assumption of risk typical of insurance companies, or benefit plans or trust | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Real estate sales or consulting | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Securities sales or trading | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Mortgage brokering or banking | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Financial planning | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Accounting | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Legal consulting or representation | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Trustee or benefit plan administration (other than claims administration or adjusting) | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Managing General Agency | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Actuarial | <input type="checkbox"/> | <input type="checkbox"/> |

(If "Yes," please provide complete details including gross annual revenues derived from performing each such service(s).)

5. Has the Applicant ever provided services of any nature in connection with any of the following types of plans or trusts, or anticipate providing services of any nature in the next twelve months in connection with any of the following types of plans or trusts:

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Multiple employer trusts | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Self-insured plans or trust | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pension and/or Profit Sharing plans | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Employee Stock Ownership plans | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Any other benefit plan or trust other than a health benefit plan or trust | <input type="checkbox"/> | <input type="checkbox"/> |

(If "Yes," please provide complete details including gross annual revenues derived from performing services for each type of such plan(s) or trust(s).)

6. Has the Applicant ever rendered services of any nature, directly or indirectly, for, or on behalf of, or in connection with, any insurance company that has been declared insolvent (including, but not limited to, any insurance company which has underwritten any insurance contract or provided benefits under any benefit plan or trust serviced by the Applicant)? Yes No

(If "Yes," please provide complete details.)

7. Has the Applicant ever rendered services of any nature, directly or indirectly, for, on behalf of, or in connection with any benefit plan or trust that has been declared insolvent? Yes No

(If "Yes," please provide complete details.)

8. a. Does the Applicant perform initial and periodic due diligence investigations to ensure that all insurance carriers underwriting all insurance contracts or providing benefits, in whole or in part, under any benefit plan or trust serviced by the Applicant are financially solvent? Yes No
- b. Does the Applicant perform initial and periodic due diligence investigations to ensure that all self-insured plans or trusts and all benefit plans or trusts serviced by the Applicant are adequately funded and financially sound? Yes No
- c. Are any outstanding delinquent contributions currently owed to any benefit plan or trust serviced by the Applicant? Yes No

(If "Yes," please provide complete details.)

9. a. Under any circumstances, has the Applicant or any entity under the same ownership or control as the Applicant or any of its directors or officers ever provided products, equipment or supplies or services such as repair, restoration, reconstruction, salvaging, rehabilitation, recovery subrogation, medical, dental, architectural, engineering, remediation, legal representation, psychological or psychiatric counseling services in connection with any claims administration or adjusting services rendered by the Applicant? Yes No

(If "Yes," please provide complete details.)

- b. Under any circumstances, would the Applicant or any entity under the same ownership or control as the Applicant or any of its directors or officers ever provide products, equipment or supplies or services such as repair, restoration, reconstruction, salvaging, rehabilitation, recovery subrogation, medical, dental, architectural, engineering, remediation, legal representation, psychological or psychiatric counseling services in connection with any claims administration or adjusting services rendered by the Applicant? Yes No

(If "Yes," please provide complete details.)

10. Does the Applicant have a "fast-track" appeal system regarding the denial of benefits or claims or postponement of benefits or claims payments? Yes No

11. a. Do all claimants have access to a representative of the Applicant who has authority to review and decide appeals? Yes No

- b. If "Yes," please provide the average length of time required for an appeal to be reviewed and decided. (Please check and complete the appropriate response.)

(i) Within ____ hours

(ii) Within ____ days

(iii) Within ____ weeks

12. a. Does the Applicant maintain a computer system for handling claims? Yes No

(If "Yes," please complete questions 12.b., 12.c., 12.d., and 12.e.)

- b. Please provide the length of time that the current application software has been in use: _____

- c. Are there any plans to update or enhance the current application software or computer systems in the next 12 months? Yes No

(If "Yes," please provide complete details.)

- d. Can the computer system alert the user to critical decision making factors such as eligibility requirements of claimants, limits of available insurance or benefits and status of deductible payments, cancellations and reinstatements of coverage/benefits under each and every insurance contract, self-insured plan or trust or benefit plan or trust for which the Applicant provides claims administration adjusting services? Yes No

(If "No," please provide complete details of the manual systems in place to track such critical decision making factors.)

- e. When is the computer system updated following the addition of new insurance contracts, self-insured plans or trusts or benefit plans or trusts or a change in existing insurance contracts, self-insured plans or trusts or benefit plans or trusts for which the Applicant provides claims administration or adjusting services?

(Please check and complete the appropriate response.)

- (i) Within ____ hours
 (ii) Within ____ days
 (iii) Within ____ weeks

- f. Do all computer or electronic systems (including any and all components or codes thereof) owned or used by the Applicant properly read and process any date outside the 1900 to 1999 year range, i.e. are all such computer or electronic systems (including all components or codes thereof) compliant with year 2000? Yes No

(If "No," please provide details on a separate sheet of paper, of any procedures that have been, or will be implemented to ensure that all computer or electronic systems owned or used by the Applicant will read and process dates outside the 1900 to 1999 year range, including the estimated date when the Applicant will be able to answer "Yes" to 12.f.)

The undersigned authorized agent of the Prospective Insured understands that the information provided in this supplement becomes a part of the Miscellaneous Professional Liability Application and is subject to the same representations and conditions.

Signature of Applicant

Title

Date

WARNING: 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, incomplete, or misleading information, or conceals information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime punishable by incarceration, and shall also be subject to civil penalties.