

# LIFE INSURANCE AGENTS PROFESSIONAL LIABILITY *Application*



Underwritten by:  
**Houston Casualty Company**

Please mail or fax application to:  
**Zain Jeewanjee Insurance Agency**  
6155 Alamden Expy, San Jose, CA 95120  
Tel: 800-257-7718 Fax: 408-997-7890  
Website: www.jeewanjee.com

**NOTICE:** This is an application for claims made and reported insurance. Such insurance if accepted by the Company, subject to policy provisions, applies only to those claims which are the result of wrongful acts occurring subsequent to the Retroactive Date and which are first made against you and reported to us during the policy term or any applicable Extended Reporting Period. The policy provides that the limit of liability shall be reduced by the amounts paid for legal defense.

- Preferred Risk Characteristics**
- Retail agency only cannot insure Managing General Agents/Wholesalers
  - Application is not for use with Texas risks. Contact Rockwood for the state-specific form.
  - Have \$500,000 or less in annual commission income. *Please contact us to accommodate higher commission income.*
  - Have limited claims history

**1** Applicant's Name \_\_\_\_\_ DBA (if applicable) \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( \_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_ ) \_\_\_\_\_ Email Address \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Title \_\_\_\_\_

**2** Applicant is  Sole Proprietorship  Partnership  Corporation

**3** Date first licensed: Life/Health\* \_\_\_\_ / \_\_\_\_ / \_\_\_\_ P/C (if applicable) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Series 7 (if applicable) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*\*If less than three years, provide resumes for each agency principle.*

**4** Please check the professional designations you currently hold:  
 CLU  RHU  LUTCF  ChFC  CIC  REBC  CPCU  RPLU  Other \_\_\_\_\_

**5** Has the applicant been involved with any mergers, purchases or, acquisitions in the past five years?  Yes  No  
*If yes, please describe on a separate sheet.*

**6** Has the applicant ever had any professional license terminated or suspended?  Yes  No

**7** Have any professional liability claims been made against the applicant or any of its past or present owners, officers, partners, employees, or solicitors, or to the knowledge of the applicant on behalf of its predecessors in business, within the last five years?  
*If yes, a Supplemental Claim form must be completed and submitted with this application. The Supplemental Claim Information Form is available on the web at [www.rockwoodinsurance.com](http://www.rockwoodinsurance.com) in the Life Agents E&E section.*  Yes  No

**8** Are there any known circumstances or incidents which may result in a professional liability claim?  Yes  No  
*If yes, give details on a separate sheet.*

**9** Declarations of "LICENSED" persons, **(including yourself)**, whether owners, partners, directors, officers, or employees (selling or not).

A	NAME OF LICENSED PERSON	DESIGNATIONS CODE	COMMISSIONS	
			LAST 12 MONTHS	NEXT 12 MONTHS
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
<b>B</b>	Total Number of sub-agents, brokers, and independent contractors _____		\$ _____	\$ _____
	<b>Total Commissions</b> .....		\$ _____	\$ _____

**\*Designation Codes: O = Owner P = Partner OF = Officer/Director E = Employee** (if necessary, use a separate sheet)

**C** Unlicensed Staff: Total Number \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

**Please note that the policy covers the applicant for any liability resulting from the actions of independent contractors so long as the revenues from independent contractor(s) are indicated above.**

10 Do you verify that all non-employed sub-agents/independent contractors are required to carry Errors and Omissions coverage?  Yes  No

11 Please indicate percentages of the applicants revenue derived from each line of business written below: **The total of all lines should equal 100%.**

\_\_\_\_\_ % Life—Individual \_\_\_\_\_ % A&H—Individual \_\_\_\_\_ % Stocks \_\_\_\_\_ % Variable Annuities  
\_\_\_\_\_ % Life—Group \_\_\_\_\_ % A&H—Group \_\_\_\_\_ % Bonds \_\_\_\_\_ % Property/Casualty Products  
\_\_\_\_\_ % Fixed Annuities \_\_\_\_\_ % Mutual Funds \_\_\_\_\_ % RIA/Financial Planning \_\_\_\_\_ % All Other (Describe on a separate sheet)

\* \_\_\_\_\_ % Pension/Employee Benefit Planning \* \_\_\_\_\_ % Insurance Consulting **Please provide a brief description on a separate sheet.**

12a Does the applicant require coverage for property casualty production? .....  Yes  No *If Yes, separate application required.*

12b Does the applicant require coverage for Financial Products (Mutual Funds and Variable Annuities)? .....  Yes  No  
*If Yes, an additional premium will apply.*

12c Does the applicant require coverage for Investment Services (Stocks, Bonds, RIA/Financial Planning)? .....  Yes  No  
*If Yes, an additional premium will apply.*

**NOTE:** The activities listed in questions 14a, 14b, and 14c are subject to a sublimit: actions as a property/casualty agent; actions selling variable annuities, mutual funds, stocks, bonds; actions as a financial planner/registered investment advisor.

13 *If Yes to 12b and/or 12c please provide:* Name of Broker Dealer \_\_\_\_\_

Name of Registered Representative(s) \_\_\_\_\_

14 Does the applicant place coverage or have involvement with Self Insured/Captives or Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), Multiple Employer Trusts (MET), or Multiple Employer Welfare Arrangements (MEWA)? .....  Yes  No

**➤ If yes, please provide a brief description of activities in this area (on a separate sheet).**

15 List the top five Insurance Companies with which you place business:

Name of Insurance Company	Products Sold	% of Revenues
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %

16 Do you currently have Errors and Omissions Insurance in Force? .....  Yes  No

*If yes, what is:* Name of Insurer \_\_\_\_\_ Expiration Date \_\_\_\_\_

Retroactive Date \_\_\_\_\_ Current Limits \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_

Do you wish to purchase prior acts coverage? .....  Yes  No

**NOTE:** Prior Acts coverage may only be available if the applicant has had continuous coverage in force with no gaps. If the applicant has not carried coverage or is not able to provide proof of coverage, the retroactive date of the policy will be inception. If "Yes", proof of prior coverage will be required.

17 Limits of liability desired \$ \_\_\_\_\_ Deductible amount desired \$ \_\_\_\_\_

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY. SUCH POLICY MAY BE CANCELLED BY THE COMPANY FROM INCEPTION UPON DISCOVERY THAT THE POLICY WAS OBTAINED THROUGH FRAUDULENT STATEMENT, OMISSION, OR CONCEALMENT OF THE FACTS MATERIAL TO THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED BY THE COMPANY.

**THE APPLICANT REPRESENTS THAT THE STATEMENTS AND RESPONSES TO THE QUESTIONS ON THIS APPLICATION ARE ACCURATE AND COMPLETE. APPLICANT ALSO WARRANTS THAT SUCH STATEMENTS AND RESPONSES ARE TRUE, CONTAIN NO MISREPRESENTATIONS AND THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION OR ATTACHMENTS THERETO CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Must be signed by an owner or officer of the applicant)*

Please Print Name \_\_\_\_\_ Title \_\_\_\_\_

**Referred by:**  
Agent Name \_\_\_\_\_ E-mail \_\_\_\_\_ Tel ( \_\_\_\_\_ ) \_\_\_\_\_

# LIFE INSURANCE AGENTS PROFESSIONAL LIABILITY

## Supplemental Claim Information Form



Underwritten by:  
**Houston Casualty Company**  
 Please mail or fax application to:  
**Rockwood Programs, Inc.**  
 4001 Miller Road, Wilmington, DE 19802-1999  
 Tel: 877/242-2487 Fax: 302/762-4200  
 Website: [www.rockwoodinsurance.com](http://www.rockwoodinsurance.com)

**Applicant's Instruction:** This form is to be completed by the Applicant who has been involved in any claim or suit or is aware of any facts, circumstances, acts, errors, or omissions which may give rise to a professional liability claim. COMPLETE ONE FORM FOR EACH SUCH CLAIM OR CIRCUMSTANCE.

*If space is insufficient to answer any question fully, attach a separate sheet. Answer ALL questions completely.*

**1** Full name of Applicant \_\_\_\_\_

**2** Full name of individual(s) or firm involved in claim \_\_\_\_\_

**3** Full name of claimant \_\_\_\_\_

**4** Indicate whether:  Claim/Suit or  Incident **5** Date of alleged error \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **6** Date of claim \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**7A** Description of Claim: (Provide enough information to allow evaluation and use a separate exhibit if additional space is required)

\_\_\_\_\_  
 \_\_\_\_\_

**7B** Description of case and events \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8** Additional Defendants \_\_\_\_\_

\_\_\_\_\_

**9 IF CLOSED . . . . .**

Total Loss Paid including Deductible .... \$ \_\_\_\_\_

**10 IF PENDING . . . . .**

Claimant's Settlement Demand ..... \$ \_\_\_\_\_ Defendant's Offer for Settlement ..... \$ \_\_\_\_\_

Insurer's Loss Reserve ..... \$ \_\_\_\_\_ Deductible ..... \$ \_\_\_\_\_

Is Claim In Suit? .....  Yes  No If Yes, Amount Asked In Complaint ... \$ \_\_\_\_\_

**11** Name of Insurer \_\_\_\_\_

**12** Please describe procedures instituted to avoid like claims \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

*I understand that the information submitted herein becomes a part of my Life Insurance Agents Professional Liability Application and is subject to the same notifications, warranties and conditions.*

Applicant's Full Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

# RESUMÉ

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Position in Agency \_\_\_\_\_

## **INSURANCE EXPERIENCE**

From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_

Title \_\_\_\_\_

Job Description \_\_\_\_\_

From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_

Title \_\_\_\_\_

Job Description \_\_\_\_\_

From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_

Title \_\_\_\_\_

Job Description \_\_\_\_\_

## **INSURANCE EDUCATION**

Insurance Courses/Classes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Insurance Licenses/Designations \_\_\_\_\_

Date Licensed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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 Please mail or fax application to:  
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 4001 Miller Road, Wilmington, DE 19802-1999  
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 Website: [www.rockwoodinsurance.com](http://www.rockwoodinsurance.com)

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\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8 Additional Defendants \_\_\_\_\_

\_\_\_\_\_

**9 IF CLOSED . . . . .**

Total Loss Paid including Deductible .... \$ \_\_\_\_\_

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Claimant's Settlement Demand ..... \$ \_\_\_\_\_ Defendant's Offer for Settlement ..... \$ \_\_\_\_\_

Insurer's Loss Reserve ..... \$ \_\_\_\_\_ Deductible ..... \$ \_\_\_\_\_

Is Claim In Suit? .....  Yes  No If Yes, Amount Asked In Complaint ... \$ \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

*I understand that the information submitted herein becomes a part of my Life Insurance Agents Professional Liability Application and is subject to the same notifications, warranties and conditions.*

Applicant's Full Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_