Independent Insurance Agents

Application for Claims Made
Professional Liability Insurance Coverage

We recommend this application be submitted electronically. If you are unable to, please print and scan the document. Save to your hard drive before completing. Please complete using Acrobat Reader 8.0 or higher, which is available for free at: http://www.adobe.com/products/acrobat/readstep2.html

Your acceptance is subject to Underwriter's approval. All Questions must be answered. Please attach additional sheets for comments and explanations to Questions asked where the answer cannot be fully addressed on this application form.
The term "Applicant", as used in this application, refers to the person or entity applying for coverage and proposed to be covered under the policy, if issued, as the "First Named Insured". "Applicant" shall also mean any other person or entity applying for coverage as a "Named Insured."

1. **A.** Full Name of Applicant (Include all named insureds or branches to be covered on **Supplement Application E**): _____

B. Principal Office, Street Address: _____

City: _____ State: _____ Zip code: _____

Billing Address: _____

City: _____ State: _____ Zip code: _____

C. Home Page or Web Site: _____

D. Telephone: _____ Fax: _____ Email: _____

E. Primary Agency Contact Person: _____ Email: _____

F. Professional Association Memberships: _____

G. Agency is an IIABA state affiliate Member? ◯ Yes ◯ No Agency is a member of PIA? ◯ Yes ◯ No

H. Agency is a: ☐ Corporation, ☐ Sole Proprietorship, ☐ Partnership, ☐ Other: _____ If LLC or LLP in CA, please provide the number of endorsees declared under LLC/LLP license filling: _____

2. Number of years applicant has been in business? # _____ (Note less than 3 years, attach resumes of agency principals)

3. Any mergers, acquisitions, ownership, or cluster arrangments changes, etc. in the last 5 years? ◯ Yes** ◯ No

If yes, **Supplemental Application A. Mergers, Acquisitions and Clusters must be completed.

4. Effective and Retroactive Dates will be 12:01 A.M. Standard Time at principal office shown in Question 1.

Requested Effective Date: MM/DD/YYYY	Requested Retroactive Date: MM/DD/YYYY
_____	_____

5. Policy Limit of Liability Options (each claim/aggregate limit applies): subject to state requirements

☐ $1,000,000/1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000 ☐ $2,000,000/$2,000,000 ☐ $2,000,000/$3,000,000
☐ $2,000,000/$4,000,000 ☐ $2,000,000/$5,000,000 ☐ $3,000,000/$3,000,000 ☐ $3,000,000/$4,000,000 ☐ $3,000,000/$5,000,000
☐ $3,000,000/$6,000,000 ☐ $4,000,000/$4,000,000 ☐ $4,000,000/$5,000,000 ☐ $5,000,000/$5,000,000 ☐ $10,000,000/$10,000,000
☐ Other Options: _____

6. **A.** Deductible Options (each claim/aggregate deductible applies):

☐ $1,000/$3,000 ☐ $2,500/$7,500 ☐ $5,000/$15,000 ☐ $7,500/$22,500
☐ $10,000/$30,000 ☐ $15,000/$45,000 ☐ $20,000/$60,000 ☐ $25,000/$75,000

Deductible Type:

☐ Damages Only Option: Deductible amount applies to damage payments only (versus defense costs and damages)

☐ Damages and Defense Cost Option: Deductible amount applies to damage payments and defense costs.

7. Optional Financial Products Extensions: Categories are cumulative, so pick only one.

Coverage	Sublimit	Deductible each Claim					
◯ Variable Annuities	$1M/$1M	☐ $5,000	☐ $7,500	☐ $10,000	☐ $15,000	☐ $20,000	☐ $25,000
◯ Mutual Funds & Variable Annuities	$1M/$1M	☐ $5,000	☐ $7,500	☐ $10,000	☐ $15,000	☐ $20,000	☐ $25,000
◯ Securities, Mutual Funds & Variable Annuities	$1M/$1M	☐ $10,000	☐ $15,000	☐ $20,000	☐ $25,000		

8. **A. Total Agency Revenue*:** (Past fiscal year for All locations) _____ Estimated next 12 months: _____

* Revenue is all sources of income with the exception of premium finance charges, investment income and the applicant's profit sharing bonuses received from insurance carriers.

B. Revenue Distribution by Total Staff/All Locations:

Staff Categories	Number of Full-time	Number of Part-time
Licensed Owners & Officers		
Licensed Producers / Sales Staff (Include Independent Contractors)		
Other Licensed Staff		
Non-licensed Staff		

C. Revenue Distribution by State

Location	1(Principal Address)	2	3	4	5
City/County of Location					
State					
Revenue					
Staff Count					

D. Revenue Distribution by your Sales Activities, Products Sold and Services Provided. ENTER EACH AS % OF TOTAL REVENUE.

Commercial Property & Casualty (% of Total Revenue)	Personal Property & Casualty (% of Total Revenue)	Life, Accident & Health including Individuals & Groups (% of Total Revenue)	Financial Products Mutual Funds including variable annuities % of Total Revenue Securities	Other Services (% of Total Revenue)
% Fire - Standard	% Auto - Standard	% Life - Individual	% Variable Life	% Reinsurance Intermediary
% Fire - Non std/Fair Plan	% Auto - Non Standard and Assigned Risk Plans	% Life - Group	% Mutual Funds: Growth, Global, Sector, Theme or International Funds	% Third party Administrator - Workers Compensation
% SMP/BOP/Package	% Homeowners and Standard Fire	% A&H - Individual	% Mutual Funds - All Other	% Third party Administrator - Pension Plans
% CGL	% Fire - Non Standard	% A&H - Group	% Annuities - Equity Indexed	% TPA - EE Benefit Plans
% Umberlla/Excess	% Pleasure Boats	% Annuities - Fixed	% Variable Annuities	% Actuarial Services
% Auto - Standard	% Umbrella	% HMO/PPO	% Registered Investment Fees	% Title Insurance
% Auto - Non STD	% Other - Specify	% Other - Specify	% Stocks	% Real Estate
% Long Haul Trucking			% Bonds, High Yield	% Claims Adjustment Services
% Workers Compensation			% Bonds - All Other	% Loss Control/Risk Management
% Livestock Mortality			% Lmtd Partnerships	% Other - Specify
% Crop Coverages	Percentages should be entered as the		% REITS	
% Medical Malpractice	percent of your total revenue.		% Unregistered Securities	% Other - Specify
% Professional Liability: D&O, E&O, EPLI	All percentages together Should total 100%		% Unit Investment Trusts	
% Wet Marine			% 1031 exchanges	
% Inland Marine			% Hedge Funds	
% Bonds - Surety			% Derivatives	
% Bonds - All Other			% Real Estate Syndication	
% Aviation			% Private Investment Pools	
% Other - Specify			% Other - Specify	
			Total must = 100% :	

E. Revenue by Business Placements: Indicate how you place and bill your business

Percentage of Revenue from Specialty Market Placements for Commercial/Personal Property & Casualty *:		Revenue by Carrier Placements	Revenue by Billing Placements
Placed AS one of the following	Placed THROUGH one of the following		
% Managing General Agent	% Managing General Agent	% Admitted Carriers	% Written on a Direct Bill Basis
% Surplus Lines Broker/Non admitted markets	% Surplus Lines Broker/Non admitted markets	% Non-admitted Carriers	% Placed through a carrier's service center
% Reinsurance Intermediary	% Reinsurance Intermediary	% Un-rated Carriers	% Placed through a state administered Fund
% Wholesalers	% Wholesalers	% P&C Carriers rated less than B-, plus % life, A&H carriers rated less than A-	
		Admitted / Non-admitted Total (Must Be = 100)	

*** If Over 10% of revenue for any one or 20% in total, please Complete Supplemental Application B (1) or (2).**

F. Senior Marketing Activities

a. Target age of clientele for annuities:..... _____

b. What percent of the annuity business is marketed to seniors over 65 years of age?..... _____

c. Of the annuity business marketing to seniors over 65 years of age, what percentage of this business is deferred annuities versus immediate annuities? ..... _____

d. What kind of training do the agents receive in regard to investment suitability:

_____

e. Is any kind of oversight or suitability review performed on annuity sales to seniors: ..... ◯ Yes ◯ No

9. Agency Staff: A. **Principals, Owners, Officers & Managers: please complete Supplemental Application D for additional licensed staff**

Name	Experience			License Status			
	# Years Ins. Experience	# Years with Agency	Professional Designations	(Check all Applicable Boxes)			
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII

B. **Licensed Solicitors - all Agents, Brokers, Registered Representatives and Employees (other than Principals, Owners, Officers and Managers - please complete Supplemental Application D for additional staff**

Name	Experience			License Status			
	# Years Ins. Experience	# Years with Agency	#Yrs Series 6 or 7 Experience	Agent or Broker (Check all Applicable Boxes)			
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII
				☐ P & C	☐ L & H	☐ Series VI	☐ Series VII

10. List of top 5 Insurance Carriers with which insurance coverage is placed **(If the total equals less than 85% of your agency's total premium written, please answer by attachment to this application)**

	Insurance Carrier	Annual Premium - Volume (Past Year)	Binding Authority - Relationship	Bests - Rating
A.	_____	$ _____	◯ Yes ◯ No	_____
B.	_____	$ _____	◯ Yes ◯ No	_____

C. _____ $ _____ ◯ Yes ◯ No _____

D. _____ $ _____ ◯ Yes ◯ No _____

E. _____ $ _____ ◯ Yes ◯ No _____

11. Total number of Insurance Carriers the applicant is appointed with:..... **#** _____

12. Indicate the number of Insurance Carrier(s) that the applicant places business with that has:

A. An AM Best rating of Less than B+ : _____

B. Non-Admitted Carrier rating of Less than A- : _____

13. Office Procedures:

A. Is proof of Insurance Agents errors and omissions insurance required from agents/brokers and/or sub-agents/brokers that place business with the applicant?..... ◯ Yes ◯ No ◯ N/A

B. Is there an in-house policy/procedures manual in use? (most recent update year: _____)..... ◯ Yes ◯ No

C. Is all incoming mail date stamped?..... ◯ Yes ◯ No

D. Is there a systemized method for documenting phone calls?..... ◯ Yes ◯ No

E. Are there procedures that preserve confidential client information?..... ◯ Yes ◯ No

F. Is there an in-house training program for new employees?..... ◯ Yes ◯ No

G. What percentage of the applicant's ownership or management staff has attended Loss Prevention Seminars in the past 12 month period up to 30 days after policy effective date? Please attach Seminar Certificates..... _____ %

H. List the name and title of person(s) responsible for internal office methods/procedures and indicate percentage of time spent in this capacity:

(1) _____ _____ %

(2) _____ _____ %

14. New & Renewal Business Practices:

A. Is there an established procedure for recording client insurance requirements? ..... ◯ Yes ◯ No

B. Is a checklist used in reviewing client coverage and limit requirements?..... ◯ Yes ◯ No

C. Are written records maintained of details of all critical contacts, including verbal instruction and oral agreements?..... ◯ Yes ◯ No

D. Are signed acceptance client agreements required if more restrictive coverage and limits apply (versus the client's request for coverage / limits)?..... ◯ Yes ◯ No

E. Are policies / endorsements checked against the application and other client requests for coverage prior to delivery to clients?..... ◯ Yes ◯ No

F. Are policies / endorsements checked for accuracy and completeness prior to sending to clients?..... ◯ Yes ◯ No

G. Are umbrella/excess policies reviewed to be certain they are consistent with primary policy terms and conditions?..... ◯ Yes ◯ No

H. Are expiration lists maintained?..... ◯ Yes ◯ No

I. Are prospective "Broker of Record" client insurance needs and existing coverages reviewed promptly after accepting them as a client?..... ◯ Yes ◯ No

J. If coverage is quoted with a company that is either unrated or has less than a B+ rating from A. M. Best, Do you use a disclaimer ?..... ◯ Yes ◯ No

15. If more than one location, are your Branch Office Controls identical for all locations?..... ◯ Yes ◯ No

If No, please describe your Branch Office Controls (use attachment to this application if necessary):

_____

16. Complete if (Question 7) extension requested for Financial Products (Variable products, Group Plans, Mutual Funds or Securities) Procedures

A. List name of Broker/Dealer Organizations that account for 100% of total revenue from the applicant's Financial Product activities.

Broker Dealer Organization	City/State	Revenue
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %

B. Does the product training provided by the Broker/Dealer Organizations named in A. include regular training for sellers of Financial Products:

(1) Compliance Policies required by the Broker/Dealer ..... ◯ Yes ◯ No

(2) Federal Securities Laws ..... ◯ Yes ◯ No

(3) Self-Regulatory Organization (SRO) Rules ..... ◯ Yes ◯ No

(4) NASD Conduct Rule 2310, and any amendments ..... ◯ Yes ◯ No

C. Does the applicant keep customer complaint logs?..... ◯ Yes* ◯ No

* **If yes**, are customer complaints routed directly to the compliance officer of the appropriate Broker/Dealer organization in (A) above?..... ◯ Yes ◯ No

D. When was the last in-house or external compliance and suitability review completed by each Broker/Dealer Organization named in Question 16 A. above?

Broker /Dealer Organization	DATE (MM/DD/YYYY)

E. Do all Broker/Dealer Organizations named in (A) above have Security Broker/Dealer Professional Liability Insurance Coverage? ..... ◯ Yes ◯ No

F. Is the applicant aware of any market conduct or NASD disciplinary actions involving any of the Broker/ Dealerorganizations listed in Question 16 A. above? ..... ◯ Yes ◯ No

17. A. Insurance Agents Errors & Omissions Policy Insurance History (past 5 years, if applicable):

Insurance Carrier	effective Date MM/DD/YYYY	Policy Limit/Aggregate Each Claim	Deductible	Annual Premium $	Retro Date MM/DD/YYYY

B. Current Policy Retroactive Date (**Attach** copy of E&O policy Declaration page):..... ◯ Copy Attached ◯ NA

C. Has any policy or application for Insurance Agents Errors & Omissions insurance on behalf of the applicant or its predecessors in business, ever been declined, cancelled or refused renewal? This question is not applicable in Missouri. (*** If yes, attach explanation to this application)**..... ◯ Yes* ◯ No

18. During the past 5 years, has the Applicant made an "Adjustment" or "Goodwill Payment" in settlement of any dispute?..... ◯ Yes* ◯ No

*** If yes, attach explanation concerning payments of $500** (exclusive of company draft authority) or more to this application.

19 Have any of the principals, officers, or employees ever been subject to a complaint, reprimand, or disciplinary or criminal action by federal, state, or local authorities as a result of their professional service activities?..... ◯ Yes* ◯ No

*** If yes, attach explanation to this application**.

20. Does the applicant or any director, officer, manager, member, partner or employee or agent of the applicant proposed for coverage have knowledge of or information concerning any fact, circumstance, situation, act, error or omission which might reasonably be expected to give rise to a claim?..... ◯ Yes* ◯ No

*** If yes, attach explanation to this application**.

21. During the past 5 years, have any claims, suits, proceedings or claims for damages been made against the applicant or any proposed insured? (*** If yes, complete Supplemental Application C**.)..... ◯ Yes* ◯ No

NOTE: Provide current copy of the applicant's insurance agents errors and omissions carrier loss runs for the past 5 years. The loss runs should be dated within the past 60 days

It is agreed that if any applicant or director, officer, manager, member, partner or employee or agent of the applicant proposed for coverage has knowledge of any information concerning any such fact, circumstance, situation, act, error or omission, whether or not identified in response to Question 20 or 21, any claim arising therefrom is hereby excluded from coverage under the policy, if issued.

It is hereby agreed that the information provided above is true and correct, and is material in deciding whether to issue the above coverage or coverages to the Applicant. This supplemental application must be signed and dated by the owner, partner or a senior officer of the Named Insured.

MUST BE SIGNED AND DATED BY OWNER, PARTNER OR SENIOR OFFICER.

Name: (Print Name) _____

Title: (Print Title) _____

Signature: (Must be signed by Owner, Partner or Senior Officer) _____

Date: (MM/DD/YYYY) _____

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or submits a 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.

Arkansas Fraud Warning 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.

Colorado Fraud Warning 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance with the department of regulatory agencies.

District of Columbia Applicants 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 an applicant.

Florida Fraud Warning Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii Warning 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.

Kentucky Fraud Warning 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.

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.

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 a denial of insurance benefits.

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.

New Mexico Applicants Any person who knowingly presents a false and 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 penalties.

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 materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act which is a crime, and shall be also subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

This policy applies on a claims made basis. Please read the entire policy carefully. There is no coverage for wrongful acts prior to the indicated retroactive date. Extended Reporting Periods of 1 year and 3 years are indicated. Other than the reporting extension provided in Condition D - Reporting of Potential Claims, there is no coverage for claims reported after termination of this policy without the purchase of an Extended Reporting Period. Even with the purchase of an Extended Reporting Period coverage gaps may occur.

The rates for Claims Made Coverage are lower in the initial years of coverage based on the retroactive date than the rates for occurrence coverage, but in future years the insured should expect substantial increases.

Ohio Applicants Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilt of insurance fraud.

Oklahoma Applicants 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 a false or deceptive statement is guilty of insurance fraud.

Oregon Applicants Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application or; (2) filing a claim containing a false statement as to any material fact may be violating state law.

Pennsylvania Fraud 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 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.

Tennessee Fraud Warning It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

West Virginia Warning 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.

Supplemental Application A. Changes: Mergers, Acquisitions and Clusters

Name of Applicant: _____

A . Changes: For all mergers and acquisitions, attach that portion of the merger or purchase agreement that delineates each party's responsibility for agents acts, errors and omissions. For each change, merger or acquisition of ownership provide the following:

1. Name of entity acquired/changed/merged: _____

2 . Date of acquisition/change/merger: (MM/DD/YYYY) _____

3 . Was the name acquired/changed/merged entity retained? ◯ Yes ◯ No

4 . Do principals under present entity, own 51% or better of changed/acquired/merged entity? ◯ Yes ◯ No

5 . A . Assets and Liabilities acquired? ◯ Yes ◯ No

B . Assets only acquired? ◯ Yes ◯ No

C . Please attach the endorsement from your current E&O policy showing when the Asset (new entity) was added for prior acts coverage.

6 . Prior insurance agents errors and omissions coverage insurer and date of termination of changed/acquired/merged entity:

_____

7 . Supplemental extended reporting period purchased from prior entity's carrier? ◯ Yes* ◯ No

* If yes, provide number of years purchased (or expiration date) and limit of liability below:

_____

8 . If an Asset and Liability purchase, did prior entity sustain any claims within the past 5 years? ◯ Yes* ◯ No

* If yes, provide previous carrier claim history including date of claim, description and amounts paid or reserved by attachment to this application.

9 . Estimated past year revenue of entity acquired/merged entity: $ _____

10 . A . Estimated total increase in staff due to entity acquired/changed/merged: _____ %

B . **Licensed Staff**: # _____ **Unlicensed Staff**: # _____ **Staff selling Financial Products**: # _____

11. Will there be additional services/products offered by new entity that is not presently offered or performed by current applicant? ◯ Yes* ◯ No

* If yes, provide complete description of services/products of new entity.

_____

B . Name of Cluster: _____

1. a. Cluster entity is a(n): ◯ Corporation ◯ Partnership ◯ Association ◯ Trade Name

b. Date Cluster established: (MM/DD/YYYY) _____

c. List Applicant's ownership percentage in Cluster: _____ % d. Describe the services and/or market capabilities the Cluster provides the Applicant: _____

2 . a . Is the Cluster licensed as an agency? ◯ Yes ◯ No

b . Does the Cluster have any employees? ◯ Yes ◯ No

c . Are Cluster employees licensed agents? ◯ Yes ◯ No

d . Is the Cluster used for Marketing? ◯ Yes ◯ No

e . Is the Cluster used for Premium Accounting? ◯ Yes ◯ No

f . Does the Cluster own physical assets? ◯ Yes ◯ No

g . Other (please describe) : _____

3 . List top 5 carriers that have a contract or agreement held in the Cluster's name.

Insurance Carrier	Premium Volume $	Predominant Coverage Placed	Years Represented #

4 . List number of Cluster members: _____

5 . Do any Cluster members share offices? ◯ Yes ◯ No

6 . Have any errors and omissions claims been made against the Cluster entity? ◯ Yes ◯ No If "YES," please complete Claim Supplement C.

7 . Attach copy of Marketing Materials, Marketing Plan and/or Vision Statement ☐ Copy Attached

Supplemental Application B.
(1) Managing General Agency (MGA) Activities

Name of Applicant: _____

1. Name of Insurance Company(ies) with which there is an MGA agreement and number of years the applicant has represented each company:

_____

Name of Carrier	Type of Coverage	Insurance Carrier	Annual Premium Volume	# Year Relationship
_____	_____	_____	$ _____	# _____
_____	_____	_____	$ _____	# _____
_____	_____	_____	$ _____	# _____

2. Approximate premium volume of MGA business:..... $ _____

3. Number of agents/brokers placing business through the applicant's MGA programs:..... # _____

4. Is there a written agreement with the agent/broker who place business through the applicant?..... ◯ Yes ◯ No

* If yes, attach a copy of the agreement to this application.

5. A. Number of employees assigned to the applicant's MGA business activities:..... # _____

B. Attach name and qualifications of the key professional staff members responsible for MGA business activities to this application.

6. Has an insurance company modified the applicant's MGA authority since the agreements were signed?..... ◯ Yes* ◯ No

* If yes, attach details to this application.

Supplemental Application B (2)
Applicant Business Placed:
1. Direct With Surplus Lines Carriers
2. Through Wholesaler Brokers / Managing General Agents (MGA's)
3. PEO (Professional Employer Organization) Referrals

Name of Applicant: _____

1. List the name(s) of the surplus lines carriers (if placed direct with), wholesale brokers and/or MGA's:

Name of Carrier/Wholesaler/MGA	Type of Coverage	Insurance Carrier	Annual Premium Volume	# Year Relationship
_____	_____	_____	$ _____	# _____
_____	_____	_____	$ _____	# _____
_____	_____	_____	$ _____	# _____

2. Does the applicant require proof of insurance agents errors and omissions insurance coverage from these entities? ◯ Yes ◯ No

3. Do you only conduct business with PEO's in the states where you have a P&C license?..... ◯ Yes ◯ No

If Yes, please indicate the state(s): _____

4. List the name(s) of the Professional Employer Organization(s) (PEO) that you refer or actively sell to your clients:

_____

5. Are these PEO(s) indicated in question 4, licensed, certified, or authorized to do business in the state?..... ◯ Yes ◯ No

6. Describe the nature of the business relationship or services provided on behalf of these PEO's:

_____

7. Does your agency sell Human Resources services or products including the sale of Human Resources software?..... ◯ Yes ◯ No

Supplemental Application **C.**

CLAIM INFORMATION

Instructions: Complete a separate page for each claim

1. Name of Applicant: _____

2. Name of Person Involved in Claim: _____

3. Name of Claimant: _____

4. Date of Error: (MM/DD/YYYY) _____ 5. Date of Claim: (MM/DD/YYYY) _____

6. Name(s) of Additional Defendant(s): _____

7. Name of E&O Carrier: _____

8. Claim Status: ◯ Open ◯ In Suit ◯ Paid

9. If Paid,

   a. Amount of Damages Paid: $ _____

   b. Amount of Expenses Paid: $ _____

10. If Open, or in Suit

   a. Claimant's Settlement Demand: $ _____

   b. Defendant's Offer for Settlement: $ _____

   c. E&O Carrier Loss Reserve: $ _____

11. Act, error or omission alleged by claimant:

_____

12. Description of claim and events:

_____

13. What steps have been taken to reduce the likelihood of a reoccurrence of this type of claim?

_____

MUST BE SIGNED AND DATED BY OWNER, PARTNER OR SENIOR OFFICER.

Name: (Print Name) _____ Title: (Print Title) _____

Signature: (Must be signed by Owner, Partner or Senior Officer) _____

Date: (MM/DD/YYYY) _____

Supplemental Application D.
Additional Agency Staff

Name of Applicant: ____________________

9 . Agency Staff: **A. Principals, Owners, Officers & Managers: please complete Supplemental Application D for additional staff**

Name	Experience			License Status		
	# Years Ins. Experience	# Years with Agency	Professional Designations	(Check all Applicable Boxes)		
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII

B. Licensed Solicitors - all Agents, Brokers, Registered Representatives and Employees (other than Principals, Owners, Officers and Managers - please complete Supplemental Application D for additional staff

Name	Experience			License Status		
	# Years Ins. Experience	# Years with Agency	#Yrs Series 6 or 7 Experience	Agent or Broker (Check Applicable Boxe)		
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII
				☐ Agent Broker	☐ Series VI	☐ Series VII

Supplemental Application **E.**
Other Locations and other Named Insurds to be covered

Please list the full address of any location other that your primary location. DO NOT LIST THE PRIMARY LOCATION ON THIS PAGE.

1. Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

2. Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

3. Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

4. Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

5. Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Supplemental Application **F**.

Fireman's Fund Agency E&O Supplemental Application Employment Practices Liability Endorsement

Name of Applicant: _____

1.Please provide the following Employee count information: (Other than in "Total Number", only list people once.)

Total Number	Full Time Employees	Part-Time Employees	Independent Contractors	Seasonal	Temporary

2.Please provide the following Employment information:

A. Is there an H.R. Manager on staff or a separate H.R. Department? ☐ YES ☐ NO

B. Do you publish and distribute an employment handbook to all employees? ☐ YES ☐ NO

*If **yes** , does the handbook contain the following:*

1. Written policies and procedures against harassment and discrimination? ☐ YES ☐ NO
2. At-Will Employment statement? ☐ YES ☐ NO
3. Written procedures for employee grievances or complaints? ☐ YES ☐ NO
4. Written disciplinary process and written employee appraisal process? ☐ YES ☐ NO
5. Equal Opportunity Statement? ☐ YES ☐ NO
6. Signed Employee acknowledgement? ☐ YES ☐ NO

C. Do you use an at-will application for employment? ☐ YES ☐ NO

D. Do you use outside legal counsel for employment advice? ☐ YES ☐ NO

E. Do you have a written sexual harassment and discrimination policy? ☐ YES ☐ NO

If ***yes***, does the policy also apply to customers, clients and other non-employees? ☐ YES ☐ NO

F. Do you provide formal training for all supervisors on administering your Discrimination and Harassment Policy? ☐ YES ☐ NO

G. Do you have written policies regarding Pregnancy/Family and Medical Leave Act? ☐ YES ☐ NO

H. Do you have written policies regarding Americans with Disabilities Act (ADA)? ☐ YES ☐ NO

3. What is your average turnover rate for the past three (3) years? _____ %

4. Have you experienced in the past 24 months or do you anticipate in the next 24 months any merger, acquisition, consolidation, layoffs, reduction in force or reorganization? ☐ YES ☐ NO

*If **yes**, please provide complete details:*

5.Has there been during the past five (5) years, or is there now pending, any written demand for monetary damages or non-monetary relief, civil or criminal proceeding, formal civil administrative or regulatory proceeding, or arbitration against your Company or any director, manager, officer or any other person proposed for this insurance, involving employment related claims or incidents, or involving non-employment related discrimination or sexual harassment? ☐ YES ☐ NO

*If **yes**, please attach full details on a separate sheet.*

6.Does the applicant or any director, officer, manager, member, partner, employee or agent of the applicant proposed for this insurance have any knowledge or information of any fact, circumstance or situation indicating the probability of a Claim or action against which indemnification would be afforded by this insurance? ☐ YES ☐ NO

*If **yes**, please attach full details on a separate sheet.*

Current EPL Insurance:

Carrier	**Expiration Date**	**Limit of Liability**	**Deductible/Retention**	**Retro Date**	**Premium**

This application must by signed and dated by the Chairman, President, Chief Executive Officer, Chief Financial Officer or Chief Human Resources Executive of the Applicant, acting as the authorized agent of the persons and entity(ies) proposed for this insurance.

Signature: _____ Title: _____

Date: _____