



- General Star Indemnity Company
- General Star National Insurance Company

**MISCELLANEOUS PROFESSIONAL
LIABILITY INSURANCE
APPLICATION
<NEW BUSINESS>**

Administered by:



THIS IS AN APPLICATION FOR CLAIMS-MADE AND REPORTED INSURANCE. IT IS IMPORTANT THAT THE APPLICANT REPORT ANY CURRENTLY KNOWN CLAIMS OR CIRCUMSTANCES THAT COULD RESULT IN A CLAIM TO THE APPLICANT'S CURRENT INSURER OR PURCHASE AN EXTENDED REPORTING PERIOD ENDORSEMENT TO COVER SUCH CLAIMS OR INCIDENTS. GENERAL STAR WILL NOT PROVIDE COVERAGE FOR CLAIMS OR INCIDENTS WHICH THE APPLICANT IS AWARE OF PRIOR TO THE INCEPTION DATE OF ANY COVERAGE THAT IS OFFERED AND ACCEPTED.

INSTRUCTIONS FOR COMPLETING APPLICATION:

Please type or print clearly in ink. All questions must be answered completely. If any questions are considered "not applicable," please explain why. If you need more space, continue on a separate sheet and indicate the question number. This Application and all supplemental forms must be signed and dated by an active Principal, Partner, Managing Member or Senior Officer of the Applicant. The original copy of the signed and dated Application is needed before any coverage can be bound. Return this and all supplemental applications to the Program Administrator at:

**V3 Insurance Partners LLC
113 General Washington Memorial Blvd., Unit B
Washington Crossing, PA 18977**

SUBMISSION ADDRESS: mpl.brokerservices@v3ins.com

Please read this entire Application carefully before signing. Whenever used in this application, the term "Applicant" means the Named Insured(s) and any other entity proposed for coverage. Please also attach the following items in support of this Application:

- Résumés of Top Three (3) Key Employees/Personnel**
- Sample copy of the Applicant's standard client contract**
- Any Supplemental Applications required**

Requested Effective Date: From _____ To _____
12:01 a.m. Standard Time at the street address of the Applicant Firm

PART I: GENERAL APPLICANT INFORMATION

1. Name of Applicant: _____
2. Applicant principal location:
 - a. Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____
 - b. Website: _____ Email Address: _____
 - c. Date Established: _____
3. a. Applicant is: Corporation Partnership Individual LLC Non-Profit

b. Applicant is: Local Regional (multi-state) National International

c. If the Applicant conducts business outside its state of domicile (principal location), please list the states and corresponding % of revenues derived from each state:

4. Is the Applicant controlled, owned, affiliated or associated with any other firm, corporation or company, or does the Applicant have any subsidiaries? Yes No
If yes, please advise:

Name of Entity	Nature of Operations	% of Ownership

5. Does any partner, owner, officer or employee of the Applicant serve as an officer or on the Board of Directors of any client or own more than a three (3) percent interest in any client? Yes No

If yes, provide a complete detail of such appointments and holdings.

Name of Individual	Client Name	Position/Directorship/Equity %

6. During the past five (5) years has the name of the Applicant firm been changed or has any other business(es) been acquired, merged into or consolidated with the Applicant firm? Yes No
If yes, provide a complete detail of transactions and detail any liabilities assumed.
-

Name of Entity	Date of Transaction	Type of Transaction	Liabilities Assumed

PART 2: APPLICANT'S DESCRIPTION OF OPERATIONS

7. Describe in detail the professional services you wish to insure (attach company brochures, advertising materials, etc., that describe these services).

8. Please provide the following information regarding your income from the above services:

a. Dates of Applicant's current fiscal period: From: _____ To: _____

b. Total Gross Annual Revenue is derived from (check all that are applicable):

- Revenues Sales Fees Commissions
 Other (please describe): _____

c.

Operating Year	Total Gross Annual Revenues	Estimated Number of Clients	% of Revenue Performed By Independent Contractors Or Sub-Consultants	% of Revenue Derived from Operations Outside the United States
Past Fiscal Year	\$		%	%
Current Fiscal Year	\$		%	%
Estimate Next Year	\$		%	%

d. Did the Applicant have a positive net income in the past 12 months? Yes No
If no, please indicated steps being taken to correct the negative net income.

e. Is the Applicant's overall net equity positive? Yes No
If no, please advise net equity and steps being taken to correct the negative net equity.

9. Please answer the following questions regarding the use of independent contractors or sub-consultants:

a. Does the Applicant utilize the services of independent contractors or sub-consultants?
 Yes No

b. Do the independent contractors or sub-consultants work exclusively for the Applicant?
 Yes No

c. Do the independent contractors or sub-consultants perform the same services as the Applicant? Yes No

d. Does the Applicant require all independent contractors or sub-consultants to carry errors and omissions insurance? Yes No

10. Does the Applicant have a physical presence (e.g. office, staff, and/or independent contractors) outside of the United States? Yes No
If yes, indicate what countries and describe operations.

11. Please describe the Applicant's five (5) largest jobs or projects during the past three (3) years:

Client*	Description of Services	Total Gross Billings
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$

*Please describe the business/industry sector of the client. The client name is not required.

PART 3: APPLICANT'S DESCRIPTION OF STAFF AND PROFESSIONAL EXPERIENCE

12. Staffing – Please provide a breakdown of Applicant's staff as follows:

	Current Year	Last Year
a. Number of Principals, Partners or Officers		
b. Professional/Technical Staff not included in #12(a) above		
c. Support or Clerical Staff		
d. Total Staff Count		

13. Does the Applicant have any staff members that are certified, licensed or registered professionals (i.e. architect, engineer, medical practitioner, attorney, CPA, actuary, insurance agent or broker, financial planner/advisor, etc.)? Yes No
 If yes, please provide individual's name, designation/affiliation and services they are providing.

Individual's Name	Designation/Affiliation	Service Being Performed

14. Has any prospective insured ever had their license revoked or suspended or been fined or disciplined in any way or been the subject of any investigation by any regulatory body relating to their profession? Yes No
 If yes, attach details.

15. Please list the qualifications of top three (3) key personnel as per below and attach resumes of each.

Name	Title & Professional Designations	% of Ownership		Years of Experience
Resident/Home Address	City	State	Zip Code	Date of Hire

Name	Title & Professional Designations	% of Ownership		Years of Experience
Resident/Home Address	City	State	Zip Code	Date of Hire

Name	Title & Professional Designations	% of Ownership		Years of Experience
Resident/Home Address	City	State	Zip Code	Date of Hire

PART 4: APPLICANT'S CONTRACT PROCEDURES

16. Does the Applicant secure a written contract or agreement for every project (provide a sample copy)? In all cases Sometimes Never Not Applicable

If not in all cases, in what percentage of your work is a contract utilized? _____%

17. Does the Applicant's written contract or agreement for professional services contain the following:

Hold harmless or indemnification clause in Applicant's favor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hold harmless or indemnification clause in client's favor	<input type="checkbox"/> Yes <input type="checkbox"/> No
A specific description of the services the Applicant is to provide	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any guarantees or warranties	<input type="checkbox"/> Yes <input type="checkbox"/> No
Outline and description of payment terms	<input type="checkbox"/> Yes <input type="checkbox"/> No

18. Does the Applicant ever enter into contracts where their fees for services provided are contingent upon the client achieving cost reductions or improved operating results? Yes No
If yes, provide a detailed description of such arrangements.

PART 5: DISCIPLINARY PROCEEDINGS AND CLAIM OR POTENTIAL CLAIM ACTIVITY

19. Has the Applicant initiated litigation against any of its clients in the past 5 years?

Yes No

If yes, provide a description of all circumstances.

20. Have any claims, suits, or proceedings been made against the Applicant, its predecessors, subsidiaries or affiliates or against any past or present partners, directors, officers, members, board members or employees within the past five (5) years? Yes No

If yes, indicate the number of such claims # _____ and please complete a separate supplemental claim application for each.

21. Having inquired of all partners, directors, officers, members, board members or employees, are you aware of any act, error, omission, personal injury, fact, circumstance, situation or incident which could be a basis for a claim or suit under the proposed insurance? Yes No

If yes, indicate the number of such matters # _____ and please complete a separate supplemental claim application for each.

22. Has the Applicant, its predecessors, subsidiaries or affiliates or any past or present partners, directors, officers, members, board members or employees ever been charged with or convicted of a felony? Yes No

If yes, please provide complete details on a separate sheet, including the present status of any individuals.

23. Has the Applicant, its predecessors, subsidiaries or affiliates or any past or present partners, directors, officers, members, board members or employees ever been investigated by and/or cited by any regulatory agency or professional association for violations arising out of their activities or services? Yes No

If yes, please complete a separate supplemental claim application for each.

NOTICE: With regard to Questions 19 - 23 above, it is understood and agreed that if any such claim, suit, proceeding, act, error, omission, dispute or circumstance exists, then such claim and/or any claim arising from such claim, suit, proceeding, act, error, omission, dispute, or circumstance is excluded from coverage that may be provided under this proposed insurance and, further, failure to disclose such claim, suit, proceeding, act, error, omission, dispute or circumstance may result in proposed insurance being void, and/or subject to rescission. Report all known claims and/or circumstances to the Applicant firm's current insurer.

PART 6: INSURANCE INFORMATION

24. a. Does the Applicant currently carry Commercial General Liability Insurance? Yes No
 If yes, please provide:
 b. Name of Insurance Carrier _____
 c. Does the Commercial General Liability Insurance policy include coverage for Products/Completed Operations hazards? Yes No
 d. Does the Applicant's Commercial General Liability Insurance policy include coverage for Advertising Injury and Personal Injury perils? Yes No

25. Has any policy or application for professional liability insurance on your behalf or on the behalf of any of your partners, owners, officer, employees, or on behalf of any predecessors in business ever been declined, cancelled, or renewal refused? Yes No
 If yes, provide details.

26. Please provide the following information on your professional liability insurance for the past three (3) years:

Name of Insurer	Limit of Liability	Deductible	Policy Period	Premium

Retroactive Date of current policy, if any: _____

27. Please select:

- a. The Limit of Liability

<input type="checkbox"/> \$100,000 / \$300,000	<input type="checkbox"/> \$500,000 / \$1,000,000	<input type="checkbox"/> \$2,000,000 / \$2,000,000
<input type="checkbox"/> \$250,000 / \$250,000	<input type="checkbox"/> \$1,000,000 / \$1,000,000	<input type="checkbox"/> \$3,000,000 / \$3,000,000
<input type="checkbox"/> \$250,000 / \$500,000	<input type="checkbox"/> \$1,000,000 / \$2,000,000	<input type="checkbox"/> \$4,000,000 / \$4,000,000
<input type="checkbox"/> \$500,000 / \$500,000	<input type="checkbox"/> \$1,000,000 / \$3,000,000	<input type="checkbox"/> \$5,000,000 / \$5,000,000

- b. The Deductible:

<input type="checkbox"/> \$0	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$10,000
<input type="checkbox"/> \$500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> Other:
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$7,500	<input type="checkbox"/> Other:

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF THE APPLICANT FIRM'S PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, the undersigned, on behalf of the Applicant and all insureds proposed for coverage, represents and agrees to each of the following five (5) items:

1. The Applicant firm has made a comprehensive internal inquiry or investigation to determine whether any Applicant firm member is aware of any act, error, omission, personal injury, fact, circumstance, situation or incident which could be a basis for a claim or suit under the proposed insurance;
2. This Application, and any required additional supplemental applications submitted to and accepted by the Company shall constitute the Application;
3. Each of the statements and answers given in this Application, and in each of the supplemental applications are:
 - a. Accurate, true and complete to the best of the Applicant's knowledge;
 - b. No material facts have been suppressed or misstated;
 - c. Representations the Applicant firm is making on behalf of all persons and entities proposed to be insured;
 - d. A material inducement to the Company to provide insurance, and any policy issued by the Company is issued in specific reliance upon these representations.
4. This Application, along with each of the supplemental applications are hereby deemed to be attached to, and incorporated into, any policy contract that is issued, whether or not any of the supplemental applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the supplemental applications are signed or dated; and.
5. The Applicant agrees to promptly report to the Company, in writing, any material change in its operations, conditions, or answers provided in this Application, or any supplemental applications, that may occur or be discovered between the date of completion of such Application(s) and the inception date of any policy issued by the Company. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance, including any bound coverage.

Notice to California Applicants:

NOTICE:

1. THE INSURANCE POLICY THAT YOU ARE APPLYING TO PURCHASE, OR, IF APPLICABLE, HAVE PURCHASED, 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 WHICH APPLIES 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 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-HELP (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 FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU.

Notice to Rhode Island Applicants:

NOTICE

THIS INSURANCE CONTRACT THAT YOU ARE APPLYING TO PURCHASE, OR, IF APPLICABLE, HAVE PURCHASED, HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

Notice to South Carolina Applicants:

This company has been approved by the director or his designee of the South Carolina Department of Insurance to write business in this State as an eligible surplus lines insurer, but it is not afforded guaranty fund protection.

Notice to Virginia Applicants:

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
RULES GOVERNING SURPLUS LINES INSURANCE
VIRGINIA FORM SLB-9

DATE _____

Applicant/Insured _____

Name of Non-Admitted Insurer (If available) _____

Policy No. _____

NOTICE TO INSURED

THE INSURANCE POLICY THAT YOU HAVE APPLIED FOR HAS BEEN PLACED WITH OR IS BEING OBTAINED FROM AN INSURER APPROVED BY THE STATE CORPORATION COMMISSION FOR ISSUANCE OF SURPLUS LINES INSURANCE IN THE COMMONWEALTH, BUT NOT LICENSED OR REGULATED BY THE STATE CORPORATION COMMISSION OF THE COMMONWEALTH OF VIRGINIA. THEREFORE, YOU, THE POLICYHOLDER, AND PERSONS FILING A CLAIM AGAINST YOU ARE NOT PROTECTED UNDER THE VIRGINIA PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION ACT (ss 38.2-1600 et seq.) OF THE CODE OF VIRGINIA AGAINST DEFAULT OF THE COMPANY DUE TO INSOLVENCY. IN THE EVENT OF INSURANCE COMPANY INSOLVENCY YOU MAY BE UNABLE TO COLLECT ANY AMOUNT OWED TO YOU BY THE COMPANY REGARDLESS OF THE TERMS OF THIS INSURANCE POLICY, AND YOU MAY HAVE TO PAY FOR ANY CLAIMS MADE AGAINST YOU.

(Name of Surplus Lines Broker)

(License Number)

(Broker's Mailing Address)

FRAUD WARNING

Notice to Applicants of all states except Colorado, Louisiana, New York, and Pennsylvania:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

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 claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

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 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 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 Pennsylvania Applicants:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

This Application must be signed and dated by a Principal, Partner, Managing Member or Senior Officer of the Applicant. Electronically reproduced signatures will be treated as original.

Date (Mo./Day/Yr.)

Applicant Signature

Print or Type Name

Title