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| ExecutivePerils  T:310⋅444⋅9333 • F:310⋅444⋅9355 • Web: [www.eperils.com](http://www.eperils.com) • CA Lic# 0E36308  dba: Executive Perils Insurance Services |

APPLICATION FOR SPECIFIED PROFESSIONS PROFESSIONAL LIABILITY INSURANCE

**(Claims- Made Basis)**

1. Answer all questions. If the answer requires detail, please attach a separate sheet.

2. Application must be signed and dated by owner, partner or officer.

3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

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| **1. APPLICANT INFORMATION** | | | | | | |
| a. Full name of Applicant: | | | | | | |
| b. Principal Office Address: | | | | | | |
| c. Addresses of Branch Offices: | | | | | | |
| d. Number of Employees: Full time:  Part time:  Seasonal: Total : | | | | | | |
| e. [  ] Corporation [  ] Partnership [  ] Individual [  ] Other Date established: | | | | | | |
| f. Please list and describe affiliations with other firms: | | | | | | |
| Yes No  g. (i) In the past five years has your name changed?  (ii) Has any other business been purchased?  (iii) Has any merger taken place?  If Yes, please provide or attach details - including any changes in operations and key employees;. | | | | | | |
| h. (i) Limits of Liability requested: | $500,000 | $1,000,000 | | $2,000,000 | Other | |
| (ii) Deductible (per claim) requested | $2,500 | $5,000 | | $10,000 | $25,000 | Other |
| **2. PROFESSIONAL ACTIVITIES AND SPECIALTY** | | |  | | | |
| a. Please describe the professional activities for which coverage is desired and indicate the percentage of gross receipts derived from each activity. | | | | | | |

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| b. Fees and Receipts:  Estimate for Coming Year: $  Past 3 Years:  Last year: $  Previous Year $  Previous Year $ | | | | | |
| c. Are you engaged in any business or profession other than as described in Item 2(a)? Yes  No  If Yes, please explain: | | | | | |
| d. Have you established a quality control and/or continuing education program to limit professional liability exposure?  Yes  No If “Yes” Please explain: | | | | | |
| **3. CLAIMS/HISTORY** | | | | | |
| Please attach details for any “Yes” answers.  a. List any professional liability claims actually made against you in the past five years, including status of claim, amounts demanded or paid, date of claim, and action taken to prevent the same type of claim in the future. | | | | | |
| 1. Please list any known incidents, which might give rise to a professional liability claim. | | | | | |
| c. Has any insurer canceled or refused to renew any similar insurance during the past five years?  Yes  No | | | | | |
| d. Previous coverage: | | | | | |
| Policy  Period | Insurer | Indicate whether  claims made or  occurrence policy | Limits of Liability | Deductible | Retro  Date |
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| **4. ADDITIONAL INFORMATION** |
| a. Please attach copies of:  (i) Advertisements, brochures, descriptive literature;  (ii) Sample contract for services between you and your clients; and  (iii) Latest financial data (annual report or balance sheet and income statement). |
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| NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.  WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to any Company and/ or, Underwriting Manager**    Name of Applicant Title (Officer, partner, etc.)    Signature of Applicant Date  Signing this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued. |

**Please note; the following “supplemental application” is required**

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THIRD PARTY ADMINISTRATORS SUPPLEMENT

APPLICANT’S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.

2. Application must be signed and dated by owner, partner or officer.

3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

|  |  |  |  |  |
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| 1.NAME OF APPLICANT: | | | | |
|  | | | | |
| 2.OPERATIONS: | | | | |
| a. Number of accounts: |  | | | |
| Number of plans administered: |  | | | |
| Number of participants of plans administered: |  | | | |
| b. What types of clients do you serve? |  |  | | |
| Single Employer Plans | **%** | | | |
| Multi-Employer Plans Total Annual Revenues: | **%** | | | |
| Multi - Employer Trusts (MET’s) | **%** | | | |
| Multi - Employer Welfare Arrangements | **%** | | | |
| (MEWA’ s) | **%** | | | |
| Corporate Plans | **%** | | | |
| Taft—Hartley Plans | **%** | | | |
| Public/Government Plans | **%** | | | |
| Pension arid/or Profit Sharing Plans | **%** | | | |
| Association Plans | **%** | | | |
| Other: (specify): | **%** | | | |
|  | | | | |
| c. Procedures utilized to ensure plans administered comply with ERISA: | | | | |
| d. Are actuarial certifications reviewed by a member of the Society of Actuaries or American Academy of Actuaries? | | | Yes | No |
| e. Do you or any of your principals or retain ownership interest in and/or act as a partner, director, office or trustee for any clients in any plan? | | | Yes | No |
| If “Yes”, please provide complete details: | | |  |  |

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|  | | | | | | | | | | |
| f. Total Annual Contributions to Self Insured Plans Administered: | | | | | | $ | | |  | |
| Total Dollar Amount of Claims Paid | | | | | | $ | | |  | |
| Last year: | | | | | | $ | | |  | |
| Claim Draft Limit: | | | | | | $ | | |  | |
|  | | | | | |  | | |  | |
| g. Five Largest Accounts: | | | | | | | | | | |
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| h. Total amount of applicants Fidelity Bond: $ | | | | | |  | | | |  |
|  | | | | | |  | | | |  |
| 3 FEES | | | | | | | | | | |
| a. Total Annual Revenues | | 2 Years Prior | | 1 Years Prior | Current Year | | | Next Year | | |
|  | | $ | | $ | $ | | | $ | | |
|  | | | | | | | | | | |
| b. Percentage of fees derived from: | | | | | | | | | | |
| Administration of health plans | | | | | | | **%** | | | |
| Administration of pension plans | | | | | | | **%** | | | |
| Administration of self insured workers’ compensation: | | | | | | | **%** | | | |
| Placement of stop loss or reinsurance products | | | | | | | **%** | | | |
| Placement of L/A&H insurance to fund plans administered by applicant | | | | | | | **%** | | | |
| Placement of L/A&H insurance other than | | | | | | | **%** | | | |
| Placement of P&C insurance | | | | | | | **%** | | | |
| Loss control services (Please describe on separate attachment | | | | | | | **%** | | | |
| Consulting services (Please describe or by separate attachment) | | | | | | | **%** | | | |
| Actuarial Services | | | | | | | **%** | | | |
| Utilization Review | | | | | | | **%** | | | |
| Other (Please specify.):  . | | | | | | | **%** | | | |
|  | | | | | | |  | | | |
| 4. Staff | | | | | | | | | | |
| Please indicate number of employees by classification: (e.g. Employees Actuaries – 2 or Claims Examiners –4) | | | | | | | | | | |
|  | Job Classifications | | Number of Employees | | | | | | | |
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| 5. CLAIMS | | | | |
| a. Have any claims been made during the past five years against you, or past or present partners, executive officers, directors, solicitors, office brokers, employees, predecessors in business or against any corporation that you were formally employed by, , associated with or had an interest in? | | Yes | | No |
| If Yes, please provide details or attach statement giving details including dates, basis of claim, amount of claim, deductibles, payments or open reserves: | | | | |
| b. Are you, or any of its officers, directors, solicitors, office brokers or employees aware of any circumstances which may result in a claim against you, your predecessors n business or any past or present partner, officer, director, solicitor, office broker or employee? | | | Yes | No |
| If Yes, please provide details or attach statement giving full details: | | | | |
|  | | | | |
| I understand information submitted herein becomes a part of my application for Errors and Omissions insurance and is subject to the same representations and conditions | | | | |
|  | | | | |
|  |  | | | |
| Name of Applicant | Title | | | |
|  | | | | |
|  |  | | | |
| Signature of Applicant | Date | | | |
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|  | | | | |
| Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance. | | | | |

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