

GENERAL INFORMATION

1. Full Name of Applicant: _____

Address: _____
Street City/State Zip

a. Other entities to be considered as Insured? Yes ___ No ___
If Yes, by separate attachment provide name, relationship to Applicant, operations description and revenue.

b. Other locations? Yes ___ No ___ If Yes, by separate attachment please provide addresses.

Applicant's Website Address: _____ Telephone #: (_____) _____

2. Applicant is: ___ Individual ___ Partnership ___ Corporation ___ LLC ___ Non-Profit Organization
Other: _____

3. Date Firm Established _____ (mm/dd/yy)

4. Has the name of the firm ever changed? ___ Yes ___ No

5. Have there ever been any acquisitions, consolidations, dissolution or mergers? Yes ___ No ___ If yes, please explain.

6. Is the firm engaged in, owned by, associated with or controlled by any other business? ___ Yes ___ No

If Yes, please explain.

PROFESSIONAL SERVICES AND SPECIALTY

7. a. Describe in detail your professional services and indicate the percentage of gross receipts/revenue derived from each activity:

Table with 2 columns: Description of Professional Service, % of Revenue. Includes three rows of blank lines for data entry.

b. Gross Annual Receipts/Revenues: Last 12 Months \$ _____ % Foreign _____
Next 12 Months \$ _____ % Foreign _____

If Foreign Revenue is involved, please list the countries: _____

c. Describe Applicant's five largest jobs in the last three years:

Table with 3 columns: Client Name, Professional Services, Gross Revenues. Includes five rows of blank lines for data entry.

d. Were more than 50% of the Applicant's gross revenues for any of the last three years derived from any one client?
___ Yes ___ No

If Yes, specify client, professional services and duration of contract.

8. a. Total number of employees: Full-Time _____ Part-Time _____
Partners/Officers: _____ Administrative/Clerical: _____
Professional/Technical: _____ Other (Please Describe): _____
- b. Do you have any licensed professionals on staff? ___ Yes ___ No
If Yes, please provide details. _____
9. Does the Applicant utilize the services of independent contractors? ___ Yes ___ No
- a. If Yes, do you require independent contractors to carry professional liability insurance? ___ Yes ___ No
- b. If Yes, do you require independent contractors to carry Commercial General Liability Insurance? ___ Yes ___ No
10. Is Applicant engaged in any business/profession other than as stated in question 7a? ___ Yes ___ No
If Yes, please provide details by separate attachment.
11. Does Applicant contemplate any change in services or emphasis planned for the next 12 months? ___ Yes ___ No
If Yes, please provide details by separate attachment.
12. Is the applicant a member of any professional associations or organizations? ___ Yes ___ No
If yes, please list _____

CLAIMS/HISTORY

13. PROFESSIONAL LIABILITY COVERAGE FOR LAST 5 YEARS (if NONE check here [])

| INSURER | LIMITS (per claim/agg) | DEDUCTIBLE | PREMIUM | POLICY PERIOD |
|---------|---------------------------|------------|---------|---------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

14. What is the **retroactive date** of your current Professional Liability policy? _____ (mm/dd/yy)
15. Is the applicant insured under a Commercial General Liability policy? ___ Yes ___ No
If Yes, please attach a copy of the declarations page.
16. Has any insurer cancelled/refused to renew any similar coverage during the last 5 years? ___ Yes ___ No
If Yes, please provide details on a separate attachment .

17. Has any professional liability claim or suit been made against Applicant, any predecessor in business or against any past or present employee/partner/officer(s)? Yes No

If Yes, please complete the Supplemental Claim Information Form at the end of this application for each claim. Also, please attach five years of currently valued company loss runs.

18. Is the Applicant aware of any circumstance or incident which may result in any claim against them or any predecessor in business or any past or present employee/partner/officer(s)? Yes No

If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status on a separate attachment.

CYBER/TECHNOLOGY

Does applicant currently have or has applicant ever had insurance coverage for Cyber / Technology Errors & Omissions? Yes No

1) Please describe your security measures utilized to protect your computer network and systems.

2) a. Do You utilize encryption for electronic data at rest? Yes No
b. Do You utilize encryption for data transmitted via wireless? Yes No

3) Please describe security measures and procedures used to protect sensitive data in your care, custody and control.

4) Please describe security measures and procedures used to secure, protect, monitor and track mobile hardware (laptops, communication devices, etc.).

5) Have you experienced any security breaches or data loss events? Yes No
If Yes, please explain the specifics and any action taken to prevent recurrence.



The Applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the Applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made part of the policy.

The Applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Signature of Applicant

Date

Title (Officer/Principal/Partner)

Please include by attachment to this application:

- 1. Five largest clients and description of services performed and revenue for each
- 2. Resumes of all professionals
- 3. Copies of Association Memberships, Licenses or Certifications, Brochures/Advertisements
- 4. Sample contract between Applicant and their client (s)
- 5. Most current Financial data (Annual Report or Balance Sheet)

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim or incident)

1. Name of applicant/named insured: _____

2. Name of other parties or defendants named in suit: _____

3. Date of alleged error or occurrence, or contact date: _____

4. Date claim was made: _____

5. Name of claimant: _____

6. Name of Insurance Company handling your claim: _____

7. Present status of claim or final disposition: _____

Circle One: **CLOSED** **OPEN**

8. Defense costs paid to date inclusive of any deductible: _____

9. If closed, total loss paid, inclusive of any deductible: _____

If claim is open or pending, what are the insurers reserves?

Defense: _____ Loss: _____

10. Description of case and events including allegations and assessment of liability: _

11. Claimant's last settlement demand: _____

Signature of Applicant

Date