



MISCELLANEOUS PROFESSIONAL LIABILITY INSURANCE SUPPLEMENTAL BRIDGE APPLICATION

- General Star Indemnity Company
General Star National Insurance Company

INSTRUCTIONS FOR COMPLETING SUPPLEMENTAL BRIDGE APPLICATION: Please type or print clearly in ink. All questions must be answered completely. A current copy of your most recent miscellaneous professional liability application, a current Declarations Page of your existing coverage and any supplemental applications, must be complete and must be attached to and becomes a part of this application for insurance. The original copy of the current signed and dated Application is needed before any coverage can be bound. Return this and all supplemental applications to the Program Administrator at:

SECTION I.

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

- 1. Applicant
2. Street Address: City:
County: St: Zip:
Date Established:
3. Provide total gross annual revenues for the Applicant for the past two (2) years or fiscal year period. If newly established, indicate anticipated gross revenues for the current year.
\$ Current Year
\$ Last Year

PLEASE DESCRIBE IN DETAIL THE PROFESSIONAL SERVICES YOU WISH TO INSURE (attach company brochures, advertising materials, etc. that describe these services):

[Empty box for describing professional services]

If you need more space, continue on a separate sheet and indicate the question number.

SECTION II.

- 4. DISCIPLINARY PROCEEDINGS AND CLAIM OR POTENTIAL CLAIM ACTIVITY
a. Has any Applicant initiated litigation against any of its clients in the past 5 years? Yes No
b. 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.

- c. 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.

- d. Has the Applicant, its predecessors, subsidiaries or affiliates or against 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.

- e. Has the Applicant, its predecessors, subsidiaries or affiliates or against 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?

If yes, please complete a separate supplemental claim application.

**NOTICE: With regard to Questions 4 a. – e. 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.**

**By signing this supplemental Application, the undersigned, on behalf of the Applicant firm 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 supplemental application, along with the Applicant firm's most recent miscellaneous professional liability 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 Applicants 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.

## **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.

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## **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](http://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)

**IMPORTANT NOTICE:** Failure of the Applicant firm to report any claim, or any act, error, omission or Personal Injury that might reasonably be expected to result in a claim against the Applicant firm or its lawyers, to its current insurance company BEFORE expiration of its current policy term may create a lack of coverage.

**COMPLETION OF THIS SUPPLEMENTAL APPLICATION FORM DOES NOT BIND COVERAGE. APPLICANT FIRM'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THE APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, REGARDLESS OF WHETHER IT IS ATTACHED TO THE POLICY.**

**Submitting this form and/or tendering premium does not bind the Applicant firm or the Company to complete the insurance**

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