

**INSURANCE AGENTS AND BROKERS  
 PROFESSIONAL LIABILITY RENEWAL APPLICATION**

**(This is an application for a Claims Made Policy)**

1. Name of Applicant: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax No: \_\_\_\_\_  
 Website: \_\_\_\_\_ Email: \_\_\_\_\_

2. Indicate any changes from your current policy desired upon renewal:  
 \_\_\_\_\_  
 \_\_\_\_\_

3. During the past year has your name changed, or have you purchased, been purchased, merged or consolidated with any other business?  Yes  No If "Yes", please attach details.

4. Do you anticipate any significant changes in the nature of your operation, or changes of 25% or more in the size of your operations, over the next twenty four (24) months?  Yes  No If "Yes," please attach details.

5. Indicate your total employee headcount: \_\_\_\_\_

6. Please indicate your premium volume and **gross insurance commissions and fees** for the past year and projections for current year:

<u>Year</u>	<u>P&amp;C Premiums</u>	<u>Life/A&amp;H Premium</u>	<u>Gross P&amp;C Commissions/Fees</u>	<u>Gross Life/A&amp;H Commissions/Fees</u>

7. Please indicate and describe your non-insurance revenues for the past twelve (12) months:

<u>Non-Insurance Revenue</u>	<u>Sources</u>
\$ _____	
\$ _____	
\$ _____	

8. Please list the percentage of your business derived from your activities in each role (total must equal 100%):

Agent: \_\_\_\_\_% Broker: \_\_\_\_\_% **MGA/General Agent/Program Administrator\***: \_\_\_\_\_%  
 Wholesaler: \_\_\_\_\_% Reinsurance Broker/Intermediary: \_\_\_\_\_%  
 Other : \_\_\_\_\_% (Please Specify) \_\_\_\_\_

**\*If any of your business is derived from activities as an MGA/General Agent/Program Administrator, please complete the MGA/GENERAL AGENT/PROGRAM ADMINISTRATOR Supplemental Application.**

9. Please indicate the percentage of your total premium volume from the following: **(Total of all sections combined must equal 100%)**

**Personal Lines:**

Standard Auto \_\_\_\_\_ %  
 Umbrella \_\_\_\_\_ %  
 Non-Standard Auto \_\_\_\_\_ %  
 Marine \_\_\_\_\_ %  
 Homeowners \_\_\_\_\_ %  
 Other (Specify) \_\_\_\_\_ %

**Commercial Lines:**

Auto (except long haul trucking) \_\_\_\_\_ %  
 Workers Comp (Retro) \_\_\_\_\_ %  
 Long Haul Trucking \_\_\_\_\_ %  
 Workers Comp (Non-retro) \_\_\_\_\_ %  
 BOP/SMP \_\_\_\_\_ %  
 Fidelity \_\_\_\_\_ %  
 GL/Products \_\_\_\_\_ %  
 Surety \_\_\_\_\_ %  
 Commercial Property \_\_\_\_\_ %  
 Aviation \_\_\_\_\_ %  
 Inland Marine \_\_\_\_\_ %  
 Crop \_\_\_\_\_ %  
 Ocean Marine \_\_\_\_\_ %  
 Professional Liability/D&O \_\_\_\_\_ %  
 Medical Malpractice \_\_\_\_\_ %  
 Other (Specify) \_\_\_\_\_ %

**Group Life/Accident & Health:**

Life \_\_\_\_\_ %  
 Fully Insured Health \_\_\_\_\_ %  
 LTD \_\_\_\_\_ %  
 Self-Insured Health \_\_\_\_\_ %  
 STD \_\_\_\_\_ %  
 METS/MEWAS \_\_\_\_\_ %  
 Dental \_\_\_\_\_ %  
 Stop Loss \_\_\_\_\_ %  
 Other (Specify) \_\_\_\_\_ %

**Individual Life/Accident & Health:**

Term Life \_\_\_\_\_ %  
 Whole Life \_\_\_\_\_ %  
 LTD \_\_\_\_\_ %  
 Universal Life \_\_\_\_\_ %  
 STD \_\_\_\_\_ %  
 Fixed Annuities \_\_\_\_\_ %  
 Health \_\_\_\_\_ %  
 Accident/AD&D \_\_\_\_\_ %  
 LTC \_\_\_\_\_ %  
 Credit Life \_\_\_\_\_ %  
 Split Dollar \_\_\_\_\_ %  
 Premium Financed Life \_\_\_\_\_ %  
 COLI/BOLI \_\_\_\_\_ %  
 Other (Specify) \_\_\_\_\_ %

10. Please provide a breakdown of **client** industries served for Commercial Property & Casualty placement only.

If **not** applicable, please check here

Transportation _____ %	Legal _____ %	Government _____ %
Construction _____ %	Technology _____ %	Hospitality (including bars, inns, restaurants, etc.) _____ %
Warehouse _____ %	Insurance _____ %	All Other** _____ %
Manufacturing _____ %	Medical _____ %	

\*\*Specify & Breakdown: \_\_\_\_\_

11. Please indicate if you provide the following services:

	<u>Yes</u>	<u>No</u>
A. Claims Adjusting	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," do you have the authority to deny claims?	<input type="checkbox"/>	<input type="checkbox"/>
B. Claims Draft Authority. If "Yes," indicate maximum amount: _____	<input type="checkbox"/>	<input type="checkbox"/>
C. Inspections, Safety Engineering, Loss Control or Risk Management	<input type="checkbox"/>	<input type="checkbox"/>
D. Policy Issuance	<input type="checkbox"/>	<input type="checkbox"/>
E. TPA Services. If "Yes," please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		
F. Reinsurance Placement	<input type="checkbox"/>	<input type="checkbox"/>



- G. Actuarial Services
- H. Underwriting. If "Yes," complete the MGA Supplemental Application.

12. Have you had any agency contracts cancelled by any insurance carrier for reasons other than lack of production?  
 Yes  No If "Yes," attach details.

13. Changes:

- A. Has there been a change of greater than 10% (increase or decrease) in any of the lines of business placed by you during the past policy period?  Yes  No If "Yes," attach details.
- B. Have you placed business with any insurers that were not listed on your previous application?  
 Yes  No If "Yes," attach details.
- C. Have you or any of your directors, officers, employees or partners been the subject of a disciplinary action, investigation or complaint during the past policy period as a result of any professional activities?  Yes  No If "Yes," attach details.

All written statements and materials furnished in conjunction with this application are hereby incorporated into this application and made a part hereof.

This application does not bind you to buy, nor us to issue the insurance, but it is agreed that this application shall be the basis of the contract between us should a policy be issued, and it will be attached to and made a part of the policy. You declare that the statements set forth in this application are true. You agree that if the information supplied in this application changes between the date stated below and the time when the policy is issued, you will immediately notify us of such changes, and we may withdraw or modify any outstanding quotations and/or authorizations or agreements to bind the insurance.

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Name (Please Print or Type)

\_\_\_\_\_  
 Title (Please Print or Type)

\_\_\_\_\_  
 Date (MM / DD/ YYYY)

\_\_\_\_\_  
 Print or Type Name Agent/Broker for Applicant

\_\_\_\_\_  
 Signature Of Agent/Broker

\_\_\_\_\_  
 Print or Type Name of Insurance Brokerage

\_\_\_\_\_  
 Title Of Agent/Broker

\_\_\_\_\_  
 Date (MM / DD/ YYYY)

**Send Completed Application To:**



2 Waterside Crossing  
 Windsor, CT 06095  
 ☎: 860-903-0032  
 📠: 860-903-0001  
[www.BusinessRiskPartners.com](http://www.BusinessRiskPartners.com)

**SUPPLEMENTAL PRIVACY & INFORMATION SECURITY LIABILITY APPLICATION**

**This is an application for a Claims Made policy. Please read the entire policy carefully.**

1. Name of Applicant: \_\_\_\_\_
2. Does the Applicant have a written corporate-wide privacy/information security policy? Yes\_\_\_\_ No\_\_\_\_  
 If yes, please attach a copy.
3. Please provide details of the volumes of personally identifiable information which is handled, processed or stored by the Applicant:

Type of information	Number of records stored or processed annually	Encryption capabilities (YES / NO)			
		At rest	In transit	In mobile devices	Back up tapes
Social security numbers, government ID or driver license information					
Financial information (e.g. banking information)					
Payment card data					
Personal health information					
Other (please specify):					

4. How often are the Applicant's privacy/information security policies reviewed and updated? \_\_\_\_\_
5. Has the Applicant's privacy/information security policies been reviewed by a qualified attorney? Yes\_\_\_\_ No\_\_\_\_
6. Does the Applicant employ a chief privacy/information security officer? Yes\_\_\_\_ No\_\_\_\_  
 If no, what position is responsible for management of, and compliance with the Applicant's privacy/information security policies? \_\_\_\_\_
7. Within the past two (2) years has the Applicant completed any internal or external privacy/information security audit or received any privacy/information security certification? Yes\_\_\_\_ No\_\_\_\_  
 If yes, please describe: \_\_\_\_\_
8. Does the Applicant have a document retention and destruction policy? Yes\_\_\_\_ No\_\_\_\_  
 If yes, please describe: \_\_\_\_\_
9. Does the Applicant restrict access to private consumer information or customer files to employees on a business-need to know basis? Yes\_\_\_\_ No\_\_\_\_  
 If Yes, please describe: \_\_\_\_\_

- 
10. Does the Applicant provide training for employees on privacy and information security issues?  
Yes\_\_\_\_ No\_\_\_\_  
If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
11. Does the Applicant's contracts with vendors or others with whom it shares personally identifiable information require the other party to defend and indemnify the Applicant for legal liability of the vendor or other party?  
Yes\_\_\_\_ No\_\_\_\_  
If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
12. Does any Applicant, director, officer, employee or other proposed Insured have knowledge or information of any fact, circumstance, situation, event, or issue which may give rise to a Claim against any Insured for invasion of or interference with any right of privacy, wrongful disclosure of personal information, or violation of any privacy related statute or regulation?  
Yes\_\_\_\_ No\_\_\_\_  
If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
13. During the past three (3) years, has anyone made any Claim against the Applicant for invasion of or interference with any right of privacy, wrongful disclosure of personal information, or violation of of any privacy related statute or regulation?  
Yes\_\_\_\_ No\_\_\_\_  
If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

**I UNDERSTAND INFORMATION SUBMITTED HEREIN BECOMES A PART OF MY INSURANCE AGENTS AND BROKERS PROFESSIONAL LAIBILITY APPLICATION AND IS SUBJECT TO THE SAME REPRESENTATION AND CONDITIONS.**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABILITY INSURANCE

### THIRD PARTY ADMINISTRATOR SUPPLEMENTAL APPLICATION

**Note: This supplemental application becomes a part of your application for coverage with the Company and therefore forms a part of the policy if coverage is bound.**

1. Name of applicant: \_\_\_\_\_
2. Please check applicable services provided or contracted for by your firm as a Third Party Administrator and where applicable advise premium and gross commission/revenue by coverage/service type:

Claims administration – please indicate claims types, i.e., Workers Comp, etc.  
\_\_\_\_\_

Cost Containment \_\_\_\_\_

COBRA Compliance \_\_\_\_\_

ERISA Compliance \_\_\_\_\_

Section 125 (Cafeteria Plan) Administration \_\_\_\_\_

Pension Benefits Administration \_\_\_\_\_

Actuarial Services \_\_\_\_\_

Utilization Review (pre-certification) \_\_\_\_\_

Medical Bill Review \_\_\_\_\_

Structured Settlements \_\_\_\_\_

Placement of Reinsurance / Stop-Loss or other type of coverage. \_\_\_\_\_

Was this commission / revenue included in the main insurance application to which this supplemental application will attach?  Yes  No

Other \_\_\_\_\_

Other \_\_\_\_\_

3. Please list clients for whom you provide Third Party Administration Services:

Name of Client	Client Type(s)*	Gross Revenue by Client

\* Examples of client type: Municipality, Union, Multiple Employer Trust / Multiple Employer Welfare Arrangement, HMO, PPO, Hospital, Physician Practice, Captive Insurance Program, Risk Retention Group, Insurance Company, MGA, GA. If more than one category of Client Type applies, state so.

4. a) Do you use your own standard client contract for **all** TPA Services you provide?  Yes  No

b) If “yes” to 5a, please provide a copy of your standard contract. If “no” to 5a, please provide copies of your three largest client contracts.

5. Please provide resumes of key agency personnel with TPA experience.

*Completion of this application or tendering of premium does not bind coverage. This application is subject to company underwriting guidelines.*

*Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for Insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent Insurance act which is a crime.*

Insured Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_