

**APPLICATION FOR MISCELLANEOUS PROFESSIONAL  
LIABILITY INSURANCE  
(CLAIMS MADE)**

1. Full Name of Applicant: \_\_\_\_\_

(Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. Mailing and Location Address: \_\_\_\_\_

(If multiple addresses include an attachment with a complete schedule of all locations)

3. Web Site Address (if applicable): \_\_\_\_\_

4. Date Established: \_\_\_\_\_ 5. Type of Entity: \_\_\_ Corp \_\_\_ Partnership \_\_\_ Individual \_\_\_ Other: \_\_\_\_\_

6. Is this entity owned by, associated with or controlled by any other entity? \_\_\_ Yes \_\_\_ No If Yes, please give details. \_\_\_\_\_

7. a) Describe, in detail, the professional activities for which coverage is desired: \_\_\_\_\_

b) Indicate the percentage of revenue derived from each of the above activities: (Attach a separate sheet if more room needed)

Description of professional service:	% of Revenue
_____	_____ %
_____	_____ %
_____	_____ %

8. Estimated Revenues for the next 12 months: \$ \_\_\_\_\_ For the last 12 months: \$ \_\_\_\_\_

9. a. What is your total number of employees: \_\_\_\_\_ (Please break down into the following categories)

Full Time	_____	Part Time	_____
Volunteer	_____	Independent Contractor	_____
Other	_____ (Describe: _____)		

b. What services are performed by independent contractors? \_\_\_\_\_

c. Do you require independent contractors to carry professional liability insurance? \_\_\_ Yes \_\_\_ No

d. Do you require independent contractors to carry Commercial General Liability insurance? \_\_\_ Yes \_\_\_ No

10. Do you have any licensed professionals on staff? \_\_\_ Yes \_\_\_ No If Yes, please provide details. \_\_\_\_\_

11. Is the applicant engaged in any business or profession other than as described in Question 7a? \_\_\_ Yes \_\_\_ No

If Yes, please provide details. \_\_\_\_\_

12. Does the applicant anticipate any changes in their operations over the next 12 months?  Yes  No If Yes, please provide details. \_\_\_\_\_

13. Is the applicant a member of any professional associations or organizations?  Yes  No If Yes, please list. \_\_\_\_\_

14. Please provide information as respects the last five years of professional liability coverage beginning with most current coverage:

Carrier	Limit	Deductible	Premium	Policy Term
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed?  Yes  No If Yes, please provide details including name of carrier and dates. \_\_\_\_\_

17. Has any claim ever been made against the applicant or any of its employees? Yes  No  If Yes, please complete the Supplemental Claim Information Form at the end of this application for each and every claim. Also, please attach five years of currently valued company loss runs.

18. Is the applicant aware of any circumstances which may result in any claim against them or their employees?  Yes  No If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status. \_\_\_\_\_

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 statement and representations made in this application and this application will be made a 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 or Authorized Representative

\_\_\_\_\_  
Date

Please attach the following documents to this application:

- Resumes or CV's on principals and partners
- Copies of brochures, marketing or advertising materials.
- Five years of currently valued company loss runs.
- List of your five most recent clients with a description of the work you performed for each and contract amount.
- Copies of sample contracts with your clients.

**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. Claimants last settlement demand: \_\_\_\_\_

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**