

Personal Lines Insurance Agents Professional Liability

INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABILITY APPLICATION

All questions must be answered and application must be signed by applicant. This is an application for Claims-Made Insurance.

PART I - AGENCY DETAILS

1. Applicant name: _____
 Home Office address: _____
 City: _____ State: _____ Zip Code: _____
 Phone _____ Fax: _____ Website: _____
2. a. Is the applicant a:
 Corporation Partnership LLC Sole Proprietor Independent Contractor
- b. Does the applicant have any branch offices or subsidiaries? Yes No
 (If yes, please attach an explanation.)
- c. Is the applicant firm controlled, owned, affiliated or associated with any other firm, corporation or company? Yes No
 (If yes, please attach an explanation.)
- d. During the past 5 years has the name of the firm been changed or has any other business been acquired, merged into, or consolidated with the original firm? Yes No
 (If yes, please attach an explanation including date(s) involved.)
3. Date Agency was Established _____
 (If less than three years in operation, also please attach resumes of key personnel.)
- a. If applicable, date principal of Applicant was first licensed as a Property/Casualty Agent or Broker _____
 Number of years of experience principal has as a licensed Property/Casualty Agent or Broker _____
- b. If applicable, date principal of Applicant was first licensed as a Life/Health Agent or Broker _____
 Number of years of experience principal has as a licensed Life/Health Insurance Agent or Broker _____
4. Total number of personnel for each category:

| | | |
|-----------|-----------|---|
| Full Time | Part Time | |
| _____ | _____ | Licensed Agents and Brokers (employees & principals) |
| _____ | _____ | Licensed Agents and Brokers (independent contractors) |
| _____ | _____ | Clerical |
| _____ | _____ | Other (please specify _____) |

PART II - AGENCY OPERATIONS

5. Please give the approximate percentage breakdown of the total of your premium volume and fees as:
 "Retail Agent" _____% (Business placed directly with insurance companies, JUA's or assigned risk pools, etc.)
 "Retail Broker" _____% (Business placed through other agents, MGA's, wholesalers, etc.)
 "Wholesale Broker" _____% (Business received from other non-employee or contract brokers or agents and placed by your agency.)
 "Other" (explain) _____% _____
Must total 100%
6. Do you derive income from any activity/profession other than the sale of insurance products? Yes No
 (If yes, please attach an explanation including the percentage of your total annual income derived from it.)

7. a. Do you currently act or have you acted in the past five years as an MGA, Third Party Administrator, Reinsurance Intermediary? Yes No
- b. Do you provide services for a fee as a Risk Manager/Consultant? Yes No
- (If yes, please attach an explanation including the percentage of your total annual premium volume derived from it.)

PART III - PREMIUM VOLUME INFORMATION

8. List ALL Insurance Companies with which your Agency places business: (Use attachment if necessary.)

| Insurance Company | Direct Placement? | Total Annual Premium Volume | AM Best Rating | Admitted Carrier |
|-------------------|--|-----------------------------|----------------|--|
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

9. Are there any insurance carriers with which agency contracts have been terminated in the last 5 years and with which 25% or more of your annual premium was placed. Yes No

(If Yes, attach an explanation for each termination.)

10. Breakdown of annual written premium volume by line of coverage, and gross receipts if applicable as of this date

Date: ____/____/____ Commission receipts, latest 12-month period: _____

By signing this application, the Applicant represents that the written premium figures, and gross receipts if applicable provided in question 10 are an accurate reflection of written premium at the time of signing the application. The Applicant further agrees to provide, at the Company's request, full disclosure of the agency's books and records for premium audit purposes. If an audit reveals a material change in premium than stated on the application, then the company is entitled to collect additional earned premiums, cancel or rescind coverage.

| | |
|--|---|
| <p>10a. PERSONAL LINES:</p> <p>Automobile - Standard \$ _____</p> <p>Automobile - Non-standard (including Assigned Risk, JUA'S, etc.) \$ _____</p> <p>Homeowners - Standard \$ _____</p> <p>Homeowners - Non-standard (including Fair Plans) \$ _____</p> <p>Personal Umbrella \$ _____</p> <p>Mobile Homes \$ _____</p> <p>Other (describe) \$ _____</p> <p>TOTAL PERSONAL LINES \$ _____</p> <p>10b. COMMERCIAL LINES:</p> <p>Workers Compensation \$ _____</p> <p>Trucking (including Livery) \$ _____</p> <p>Commercial Auto \$ _____</p> <p>Commercial General Liability \$ _____</p> <p>Commercial Package including:</p> <p>Commercial Property \$ _____</p> <p>Ocean/Wet Marine \$ _____</p> <p>Inland Marine \$ _____</p> <p>Bonds \$ _____</p> <p>Aviation \$ _____</p> <p>Commercial Umbrella / Excess \$ _____</p> | <p>Volume</p> <p>Physicians, Hospitals & Professionals \$ _____</p> <p>Professional Liability, Other \$ _____</p> <p>Risk Retention Plans \$ _____</p> <p>Crop / Hail \$ _____</p> <p>Livestock \$ _____</p> <p>Other (Describe) \$ _____</p> <p>TOTAL COMMERCIAL LINES \$ _____</p> <p>10c. LIFE/ACCIDENT/HEALTH LINES:</p> <p>Life, Individual. \$ _____</p> <p>Life, Group \$ _____</p> <p>Accident, Disability & Health, Individual \$ _____</p> <p>Accident, Disability & Health, Group \$ _____</p> <p>TOTAL LIFE/ACCIDENT/HEALTH LINES \$ _____</p> <p>TOTAL ALL LINES \$ _____</p> <p>10d. FINANCIAL SERVICES INCOME</p> <p>List total gross receipts for the past twelve months for the following activities:</p> <p>Fixed Annuities \$ _____</p> <p>Variable Annuities \$ _____</p> <p>Mutual Funds \$ _____</p> <p>Stocks \$ _____</p> <p>Bonds \$ _____</p> <p>Commodities \$ _____</p> <p>Financial Plans for a Fee \$ _____</p> |
|--|---|

ONLY ANSWER QUESTIONS #11-14 IF VOLUME IS LISTED UNDER QUESTION #10c (LIFE/ACCIDENT/HEALTH LINES).

11. How many times in the past 12 months have you replaced an existing Life Insurance policy with a new policy? _____
Why were these policies replaced? _____
12. Is applicant involved in the sale, ownership, formulation, creation, administration, or operation of any self-insurance fund or program, Multiple Employer Trust, Multiple Employer Welfare Arrangement, pool, syndicate, association or other combination formed for the purpose of providing insurance or benefits when they are not fully funded by an insurance product? Yes No
If Yes, advise details _____
13. Does the applicant perform viatical settlements? Yes No
14. If you place or service any Group Life, Accident or Health insurance, what is the largest plan (based on number of participants) that you handle? _____

ONLY ANSWER QUESTIONS #15-17 IF INCOME IS LISTED UNDER QUESTION #10d (FINANCIAL SERVICES).

15. Do you have discretionary control of any clients' assets? Yes No
If yes, indicate the number of clients and the value of assets controlled: _____
16. Are you involved in the sale of structured settlement annuities? Yes No
17. Do you have any involvement in the development or solicitation of general or limited partnerships? Yes No
If yes, provide full details: _____
18. Is the applicant a captive agent? Yes No
Is applicant employed by any insurance company? Yes No
If yes to either, please answer the following.
a. Please list the name of this company: _____
b. Is professional liability already provided for business placed with this company? Yes No
19. Does the Total Insured Value of any Commercial Property or Inland Marine account written by the applicant exceed (\$1.5 million)? Yes No
(If yes, please attach a list of accounts including the total insured value.)

PART IV - CLAIM INFORMATION

Do not complete this section if this is an application for a renewal policy at the same limit of liability with one of the USLI Companies.

20. During the past five (5) years, has any claim been made or suit brought against the agency, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees, or independent contractors? Yes No
(If yes, provide details on the separate supplemental claims application.)
21. Is any owner, partner, officer, director, employee, or independent contractor aware of any circumstance, allegation, contention, or incident which may result in a claim being made against the agency, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees, or independent contractors? Yes No
(If yes, provide details on the separate supplemental claims application.)
22. In the past five years, has the applicant initiated litigation versus any carrier? Yes No

PART V - INSURANCE COVERAGE INFORMATION

23. Has any prospective insured ever had their license revoked or suspended or been fined or disciplined in any way or been the subject of any investigation by any state insurance department? Yes No
(If yes, please attach an explanation.)
24. During the past five years, has any director, officer, partner, employee, or independent contractor ever been declined, cancelled or refused renewal of their fidelity or surety bond? Yes No
If yes, provide full details: _____

25. Has any policy of or application for similar insurance on your behalf or on the behalf of any of your principals, officers, employees, or on behalf of any predecessors in business ever been declined, canceled, or renewal refused? Yes No

(If yes, please attach an explanation.)

26. Please provide the following information on your professional liability insurance for the past three years:

| Name of Insurer | Limit | Deductible | Policy Period | Premium |
|-----------------|-------|------------|---------------|---------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

27. Retroactive Date of current policy (if any): _____ / _____ / _____

28. Have you ever purchased "Extended Discovery/Reporting Period" coverage ("tail") from any prior insurer? Yes No

(If yes, please attach an explanation.)

Virginia Notice: You have an option to purchase a separate Limit of Liability for the extension period, policy common conditions VII. If you do not elect this option, the Limit of Liability for the extension period shall be part of and not in addition to the limit specified in the declarations. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

Minnesota Notice: The clause "and/or authorization or agreement to bind the insurance." is replaced with "Authorization or agreement to bind the insurance may be withdrawn or modified based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

Colorado Fraud Statement: 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.

District of Columbia Fraud Statement: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Fraud Statement: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Fraud Statement: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maine and Washington Fraud Statement: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Jersey Fraud Statement: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Fraud Statement: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio Fraud Statement: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Fraud Statement: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania Fraud Statement: 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 subjects such person to criminal and civil penalties.

Tennessee and Virginia Fraud Statement: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Fraud Statement (All Other States): 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.

New York Disclosure Notice: This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged wrongful acts that took place prior to the retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extended reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

If the primary address of the location listed in item #1 is in the state of **New York, Iowa or Florida**, the states of **New York, Iowa and Florida** require that we have the name and address of your (insured's) authorized Agent or Broker.

Name of authorized Agent or Broker: _____

Address: _____

Agent or Broker License number: _____

Mail completed Application through local Agent or Broker to: _____

The undersigned declares that to the best of his/her knowledge and belief the statements set forth herein are true, The undersigned further declares that any occurrence or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Insurer and the Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the policy.

Signature of Applicant: _____

Must be signed by a Principal, Partner or Officer of the Firm

Date: _____ Title: _____



P.O. Box 2909
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www.shellyins.com

Personal Lines Insurance Agents Professional Liability

INSURANCE AGENTS AND BROKERS SUPPLEMENTAL CLAIMS APPLICATION

Please complete this form in its entirety for all prior and pending E&O claims.

1. Name of claimant: _____
2. Date claim occurred: _____
3. Date claim reported to E&O Carrier: _____
4. Details and background of claim: _____

5. What is the status of the claim? _____
6. Defense costs paid to date: _____
7. Settlement amount: _____
8. If claim is still open, what is the reserve amount? _____
9. What remedial measures have been taken to prevent a recurrence of a similar claim?

Signature: _____ Date _____
(Principal, Partner or Officer of the Firm)

The information on this supplemental application is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as if physically attached hereto.

Personal Lines Insurance Agents Professional Liability

FINANCIAL PLANNERS ADDENDUM TO APPLICATION

Name of Applicant: _____ Date: _____

| Name of Partners, Principals, Producers, Independent Contractors selling Life/Accident/Health products | Title | Type of License | Date Licensed | # of Years of Related Experience |
|--|-------|-----------------|---------------|----------------------------------|
| | | | | |
| | | | | |
| | | | | |

1. Investment Income

List the total gross receipts for the past twelve months derived from the sales of the following products and/or activities:

Fixed Annuities \$ _____
 Variable Annuities \$ _____
 Mutual Funds \$ _____
 Stocks \$ _____
 Bonds \$ _____
 Commodities \$ _____
 Financial Plans for a fee \$ _____
 TOTAL \$ _____

2. Do you have discretionary control of any client's assets? Yes No

If yes, indicate the number of clients and the value of assets controlled: _____

3. Are you involved in the sale of structured settlement annuities? Yes No

4. Do you have any involvement in the development or solicitation of general or limited partnerships? Yes No

If yes, provide full details: _____

THIS SUPPLEMENTAL APPLICATION IS ATTACHED TO AND FORMS PART OF THE PROFESSIONAL LIABILITY APPLICATION FOR CLAIMS-MADE INSURANCE. THIS SUPPLEMENT IS SUBJECT TO THE SAME PROVISIONS CONCERNING REPRESENTATIONS MADE IN THE GENERAL APPLICATION.

 Date

 Principal, Partner, or other of the Firm

Personal Lines Insurance Agents Professional Liability

LIFE/ACCIDENT/HEALTH AGENTS SUPPLEMENTAL APPLICATION

Name of Applicant: _____ Date: _____

| Name of Partners, Principals, Producers, Independent Contractors selling Life/Accident/Health products | Title | Type of License | Date Licensed | # of Years of Related Experience |
|--|-------|-----------------|---------------|----------------------------------|
| | | | | |
| | | | | |
| | | | | |

1. Life/Accident/Health Lines:

Life, Individual \$ _____
 Life, Group \$ _____
 Accident, Disability & Health, Individual \$ _____
 Accident, Disability & Health, Group \$ _____
 Total Life/Accident/Health Lines Premium \$ _____
 Total Life/Accident/Health Lines Commission \$ _____

2. How many times in the past 12 months have you replaced an existing Life Insurance policy with a new policy? _____

Why were these policies replaced? _____

3. If you place or service any Group Life, Accident or Health insurance, what is the largest plan (based on the number of participants) that you handle? _____

4. Is the applicant involved in the ownership, formulation, creation, administration, or operation of any self-insurance fund or program, Multiple Employer Trust, Multiple Employer Welfare Arrangement, pool, syndicate, association or other combination formed for the purpose of providing insurance or benefits when they are not fully funded by an insurance product? Yes No

If Yes, please provide details. _____

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 Date

 Principal, Partner, or other of the Firm