



**SUPPLEMENTAL QUESTIONNAIRE  
FOR NEW ATTORNEYS AND  
“OF COUNSEL/INDEPENDENT CONTRACTORS”**

**INSTRUCTIONS:**

- This form is to be completed by the Insured for each new lawyer or Of Counsel/Independent Contractor joining the firm.
- If space is insufficient to answer any questions fully, attach separate sheet.
- Answer all questions completely.

**PLEASE PRINT OR TYPE**

1. FIRM NAME (If partnership or corporation, show complete firm name)

\_\_\_\_\_

Date of Hire: \_\_\_\_\_

Policy Number: \_\_\_\_\_

2. COMPLETE THE FOLLOWING FOR EACH NEW LAWYER JOINING THE FIRM:

Lawyer's Name	Social Security #	Design Code*	Year Admitted to Bar (Mo-Yr)	Years in Private Practice	Members in good standing of the following Bar Associations	Lawyer's Individual Specialty

- \* Designation Codes:   **F**-Full Time  
                                   **E**-Member/Employee of the Firm  
                                   **OC**-Of Counsel/Independent Contractor (must answer a. and b. below)  
                                   **PT**-Part Time attorney (working **20** hours or fewer per week)

a. How many hours per week does the Of Counsel attorney spend working on behalf of the firm\_\_\_\_\_.

b. Explain the relationship between the firm and the Of Counsel attorney.

\_\_\_\_\_

PAST YEARS	PROFESSIONAL LIABILITY INSURANCE COMPANY*	POLICY NUMBER	LIMIT OF LIABILITY PER CLAIM/AGGREGATE	POLICY PERIOD (month/day/year)
1			/	
2			/	
3			/	
4			/	
5			/	

- 2a. PLEASE INDICATE IF PRIOR ACTS COVERAGE IS DESIRED FOR THE NEW ATTORNEY(S):  
 NO PRIOR ACTS (If "no prior acts" is requested, there is no need to answer questions 3. and 4. Please proceed to question 5. and sign and date the form.)  
 FULL PRIOR ACTS       CONTINUE CURRENT RETROACTIVE DATE
3. ARE YOU AWARE OF ANY PROFESSIONAL LIABILITY CLAIM MADE AGAINST YOU IN THE PAST 5 YEARS, OR ANY INCIDENT, ACT, OR OMISSION WHICH MIGHT REASONABLY BE EXPECTED TO BE THE BASIS OF A CLAIM OR SUIT, ARISING OUT OF YOUR PERFORMANCE OR PROFESSIONAL SERVICES FOR OTHERS?  
 Yes    No (If "Yes", Supplemental Claim Information Form must be completed for each claim or incident.)
4. HAS ANY INSURANCE CARRIER DENIED, CANCELED OR REFUSED TO RENEW YOUR LAWYERS' PROFESSIONAL LIABILITY COVERAGE (other than for loss of market)?  
 Yes    No (If "Yes", please provide details.)
5. HAVE YOU EVER BEEN REFUSED ADMISSION TO PRACTICE, DISBARRED, SUSPENDED FROM PRACTICE, OR FORMALLY REPRIMANDED BY ANY COURT OR ADMINISTRATIVE AGENCY?  
 Yes    No (If "Yes", please provide date and explanation of any such action.)

<b>Warranty:</b> It is warranted that the information contained herein is true and deemed incorporated into the Lawyer's Professional Liability Application. I/We hereby authorize the release of claim information from any prior insurer to Arch Insurance Company			
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.			
Producer Name		Signing this form and tendering premium does not bind the applicant or the company to complete the insurance. The application must be signed to be considered for coverage.	
Signature of Owner, Officer or Partner of Firm	Date: (Mo-Day-Yr)	New Attorney Signature	Date: (Mo-Day-Yr)