TRAVELERS

Travelers 1st Choice℠

INSURANCE PROFESSIONALS LIABILITY COVERAGE
LIFE, HEALTH AND ACCIDENT INSURANCE AGENT OR BROKER
PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE RENEWAL APPLICATION

☐ **St. Paul Fire and Marine Insurance Company, St. Paul, Minnesota**
☐ **St. Paul Mercury Insurance Company, St. Paul, Minnesota**
☐ **St. Paul Guardian Insurance Company, St. Paul, Minnesota**
☐ **St. Paul Protective Insurance Company, St. Paul, Minnesota**

(Box should be checked by the underwriter after the appropriate underwriting company is determined.)

Important Note: This is an application for a claims-made policy. To be covered, a claim must be first made against an insured during the policy period or any applicable extended reporting period.

New York Defense Expenses Notice: If this policy contains an insuring agreement that includes defense expenses within the limits of coverage, payment of defense expenses may reduce the professional liability coverage limits up to 50%. If this policy contains an insuring agreement that includes a deductible that applies to defense expenses, up to 50% of the deductible amount may be applied to defense expenses.

All questions must be answered, use ink or typewriter **if not completing electronically**. Submit a current copy of all letterhead used. If the name on the letterhead differs from the name in Question 1a, provide detail on a separate attachment.

1. Applicant Information:

a. Full legal name of Applicant. *Include all agency names, trading names or DBAs under which the applicant operates.

b. Street Address: | c. City: | d. State & Zip:

e. Phone: | f. Fax:

g. E-mail Address: | h. Website Address:

i. Ownership type:
☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ LLP ☐ Other:

j. Date established:

k. Do you have any subsidiaries or branch offices? ..... ☐ Yes ☐ No
If yes provide the addresses of each office (use a separate sheet if needed).

l. Are you or any member of your firm a member of NAHU? ..... ☐ Yes ☐ No
If yes, please provide member name:

m. Are you or any member of your firm a member of any other insurance professional organization? ..... ☐ Yes ☐ No
If yes, describe:

2. Since the completion of your last application:

a. Have you changed the name of the agency or has the agency merged with, acquired, or been acquired by another agency/company? ..... ☐ Yes ☐ No

b. Have you changed your address, telephone, fax numbers or added additional locations? ..... ☐ Yes ☐ No

c. Is any Insured engaged in any other business operations, or conduct any business under any other name? ..... ☐ Yes ☐ No

If "Yes" to a., b. or c. above, provide complete details on a separate sheet.

d. Are you aware of any circumstance, allegation, contention or incident which may result in a claim being made against the agency or any of its representatives that has not already been reported to Travelers? ..... ☐ Yes ☐ No

If "Yes", complete the Supplemental Claim Form.

e. Has any insured had any license revoked or suspended or been fined or disciplined in any way by a state insurance department or other regulatory or licensing body? ..... ☐ Yes ☐ No

If "Yes", provide details on a separate sheet and a copy of the ruling.

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3. Business Breakdown:

a. Provide the gross annual commission and fee revenue from life and health products and services provided by your agency (revenue is based on commission income and fees before deduction of expenses). Include commissions or revenue that is paid by your insurance carriers directly to your non-employee producers including sub-agents, brokers, and independent contractors for business that is placed through your agency.

(Also include commission or fee revenue from mutual funds if you are requesting this optional coverage).

Revenue for the past 12 months ..... $ _____

Estimated revenue for next year (New and Renewal) ..... $ _____

b. Give the approximate percentage breakdown of the total business that is placed by you or your agency as a(n):

Agent (Personal Producing)	_____ %	Brokerage General Agency	_____ %
General Agent (P.P.G.A)	_____ %	Managing General Agency	_____ %
Broker	_____ %	Consultant (for fee)	_____ %
Life Co. General Agent	_____ %	Other (describe on separate sheet)	_____ %

c. Break down your total revenues by percentage of professional activities during the past year. Total must equal 100% of total gross revenues in 3a. above. *Provide a detailed explanation where required, attaching additional sheets if necessary.

1. "FULLY INSURED" Life and annuity policies (individual and group) issued by licensed Life Companies. _____ %
2. "FULLY INSURED" Health, A&H and Medical policies (individual and group) issued by licensed Life/A&H Companies, Regulated HMOs or Service Plans (Blue Cross/Shield) ..... _____ %
3. Administration of "FULLY INSURED" benefit plans or pension plans* Please describe _____ _____ %
4. COBRA administration or services ..... _____ %
5. Claims administration of "FULLY INSURED" benefit plans* Please describe _____ _____ %
6. Property and Casualty Insurance (except California 24 hour Worker's Compensation) **(If you desire coverage for property and casualty professional liability, you will need to complete the Property and Casualty Professional Liability Insurance Supplement.)** _____ %
7. California 24 hour type Worker's Compensation ..... _____ %
8. Mutual Fund Sales (exclusive of Annuity/Group or Employee Benefit plans) ..... _____ %
9. "Self Insured or Self Funded" Employee Benefits, Pension, and / or Medical Plans ..... _____ %

(Note: Complete the attached Self Insured/Self Funded Business Supplement if you show any revenue.)

10. All other business activities. Please describe _____ _____ %

Business Activities must total 100% **TOTAL** 0 %

Special note – Optional coverage for Mutual Funds and Property and Casualty Insurance is available under this policy. See question 6b.

d. Provide the full Names of Life/Accident & Health Companies and % of total business with each:

1st _____	_____ %	4th _____	_____ %
2nd _____	_____ %	5th _____	_____ %
3rd _____	_____ %	6th (total of all other companies)	_____ %

If more than 30%, provide name and rating of next 4 carriers

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4. Production Sources:

   a. List all actively licensed persons who represent your agency. (All licensed persons including independent contractors must be named in order for coverage to apply to that individual). Include any sub-agents / independent contractors that you wish to include under your coverage for business that they place through your agency).

*Licensed Persons	**Designation Code	Licensed for: check all that apply and include the date first licensed				
		LIFE	A&H	P&C	SEC (type/ series #)	Professional Designations Held

**Place an Asterisk next to the name of any person licensed in Kentucky.*
*** Designation Code: O=Owner, P=Partner, OF=Officer/Director, E=Employee, IC=Independent Contractor*
If additional space is needed, please provide on your letterhead.

b. Indicate the number of unlicensed support staff employees. ..... _____

c. Do you or your agency or any owner, partner or officer place business for, receive production from, or receive revenue based on the production of any non-employee producer, including sub-agents, independent contractors or other agents or brokers? ..... ☐ Yes ☐ No

(If "Yes", complete the Sub-Agent / Independent Contractor / Non-employee Producer Supplement)

d. Indicate the percentage of your total business received:

Direct from your insureds ..... _____ %

From other agents, brokers or non-employee producers who receive payment from you or from your carriers for this business ..... _____ %

e. List all states where licenses are held by you or anyone in your agency:

_____

5. Loss Control Questions:

a. Do you maintain a written office procedure manual? ..... ☐ Yes ☐ No

If yes, does it contain the following?

Procedures for handling all business transactions ..... ☐ Yes ☐ No
File documentation requirements ..... ☐ Yes ☐ No
Agency diary and recall procedures ..... ☐ Yes ☐ No
Job descriptions/responsibilities for each employee ..... ☐ Yes ☐ No
Guidelines for carrier ratings ..... ☐ Yes ☐ No
Company Information ..... ☐ Yes ☐ No
Agency statement regarding training and education ..... ☐ Yes ☐ No
Role of the computer in the agency ..... ☐ Yes ☐ No

b. Have you attended a Sponsored Loss Control Seminar in the past 12 months? (NAHU, NAIFA, PIA, IIA) .... ☐ Yes ☐ No

If yes, specify who attended: # of principals _____ # Staff/CSR _____

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6. Coverage Request:
   a. Please check the coverage limits and desired deductible:

   (Note: the $100,000/$300,000 limit option and $1,000 deductible is only available to firms with revenue less than $75,000. Availability of some Limit and Deductible options may be subject to underwriting and regulatory restrictions).

Coverage limits	Deductible
☐ $100,000/$300,000	☐ $1000 (minimum)
☐ $250,000/$750,000	☐ $2,500
☐ $500,000/$1,500,000	☐ $5,000
☐ $1,000,000/$3,000,000	☐ $7,500
☐ Other $ _____	☐ $10,000
	☐ Other $ _____

   b. Optional Coverage: The following professional coverage can be added to the policy for an additional premium charge. Please indicate each coverage desired.
      ☐ Mutual Funds
      ☐ Property and Casualty – (the **Property and Casualty Professional Liability Insurance Supplement** must be completed if coverage is desired. Coverage is subject to underwriting consideration).

   c. A sample of your stationery letterhead must be submitted with this application.

COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado
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.

Attention: Insureds in Florida
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.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania
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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

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Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and Washington
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.

Attention: Insureds in Oregon
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

YOUR SIGNATURE AND AUTHORIZATION

The undersigned authorized representative of the firm, or individual if this application is for an individual, agrees to all of the following:

- The statements and representations made in this application are true and complete and will be deemed material to the acceptance of the risk assumed by Travelers in the event an insurance policy is issued.
- If the information supplied in this application changes between the date of the application and the effective date of any insurance policy issued by Travelers in response to this application, you will immediately notify us of such changes, and we may withdraw or modify any outstanding quotation or agreement to bind coverage.
- Travelers is authorized to make an investigation and inquiry in connection with this application.
- Travelers is not bound or obligated to issue any insurance policy or to provide the insurance requested in this application.

Signature *(Partner, Member, Officer, Proprietor)*	Title	Date
Print name	Name of Firm	

This application is not a representation that coverage does or does not exist for any particular claim or loss, or type of claim or loss, under any insurance policy issued by Travelers. Whether coverage exists or does not exist for any particular claim or loss under any such policy depends on the facts and circumstances involved in the claim or loss and all applicable wording of the policy actually issued.

INSURANCE AGENT OR BROKER MUST COMPLETE THE FOLLOWING:

Submitting agency name ☐Direct ☐Sub-produced

Address (street, city, state, zip code)

Phone Fax Email

Licensed producer name License number

Please send completed forms to Mercer Consumer, a service of Mercer Health & Benefits Administration LLC, P.O. Box 8146, Des Moines, IA 50306-8146, Telephone: 888-424-2310, Fax: 515-243-2331

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