



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

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

**IMPORTANT NOTE:** This is an application for a policy which, if issued, will be on a claims-made basis. To be covered, CLAIMS must be first made against the INSUREDS and reported during the POLICY PERIOD or applicable extended reporting period. Also, the limits of liability of any such policy may be reduced by amounts paid for DEFENSE COSTS, and such payments for DEFENSE COSTS may also be applied against the deductible amount, unless we agree otherwise.

**NY DEFENSE COSTS NOTICE:** If this policy contains an insuring agreement that includes DEFENSE COSTS within the limits of coverage, and/or a deductible that applies to DEFENSE COSTS, 100% of such limit or deductible may be used up with the payment of CLAIMS or DEFENSE COSTS. Once the limit of coverage is used up, we will have no further obligation to pay any "damages" or "claims expenses".

**IMPORTANT:** All questions must be answered, use ink or typewriter **if not completing electronically**. Submit a current copy of all letterhead used. If the name 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:*

n. During the past five (5) years, has the name of the agency, ownership or principals of the agency changed, or has any other business been purchased, merged or consolidated with the agency, including the purchase of another agency's business? ..... ☐ Yes ☐ No

*If yes, provide complete details including gross revenue derived from the other business, prior professional liability insurance and claims history.*

o. During the past five (5) years, has any portion of your or business operations been sold or transferred to another person or business entity? ..... ☐ Yes ☐ No

*If yes, provide complete details including the date of sale or transfer, the amount and type of business or operations, and the person or entity that the business was sold or transferred to.*

p. Is your firm, or any owner, partner or officer engaged in any other business operations or conduct business under any other name? ..... ☐ Yes ☐ No

*If yes, provide complete details.*

- q. Are you or your agency owned by, affiliated or associated with or controlled by any other business, including any agency, brokerage or agency cluster type arrangement? ..... ☐ Yes ☐ No

*If yes, please provide details including name, percentage of ownership, description of business of parent or controlling interest, kind and amount of business derived from associated business or owner.*

## 2. 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 commission 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 and/or property and casualty insurance if you are requesting this optional coverage).*

For the past 12 months ..... \$ \_\_\_\_\_  
Estimated revenue for next year ..... \$ \_\_\_\_\_

- 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.....	_____ %
Broker (Personal Producing) .....	_____ %	Managing General Agency.....	_____ %
General Agent (P.P.G.A.) .....	_____ %	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 2a. above. *\*Provide a detailed explanation where required, attaching additional sheets if necessary.*

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|--|---------|
| 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* .....   | _____ % |
| Describe: _____  |         |
| 4. COBRA administration or services .....  | _____ % |
| 5. Claims administration of "FULLY INSURED" benefit plans* .....   | _____ % |
| Describe: _____  |         |
| 6. Property / Casualty Insurance (except California 24 hour Worker's Compensation) <b>(If you desire coverage for property and casualty professional liability, you will need to complete the Property and Casualty Professional Liability Insurance Supplement)</b> ..... | _____ % |
| 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 <b>(Complete the Self Insured / Self Funded Business Supplement if you show any percentage here)</b> .....   | _____ % |
| 10. All other business activities* .....   | _____ % |
| Describe: _____  |         |

Business Activities must total 100%

**TOTAL**

**100%**

*Optional coverage for Mutual Funds and Property and Casualty Insurance is available under this policy. See question 7b.*

- d. Full Names of Life/Accident & Health Companies and % of total business with each:

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

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

### 3. Production Sources:

List all actively licensed persons who represent your agency. (All licensed persons 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 their business placed through you or your agency**). Attach a separate list if necessary.

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

*\*Place an Asterisk next to your name if you are licensed in Kentucky.*

*\*\* Designation Code: O=Owner, P=Partner, OF=Officer/Director, E=Employee, IC=Independent Contractor*

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:  
 \_\_\_\_\_  
 \_\_\_\_\_

### 4. 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 \_\_\_\_\_*

### 5. Current Coverage:

a. Indicate your professional liability coverage for the past three years and attach a copy of your last Declarations Page. If no coverage previously existed, please state "none".

Carrier	Policy expiration date	Limits	Deductible	Annual premium	Did coverage include all Products and Carriers?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

- b. If you have not carried professional liability coverage for the past three years or have had a gap in coverage, please explain why:

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## 6. Claims / Loss History:

- a. Have you or any past or present owner, officer, employee or salespersons (whether employees or independent contractors) been the subject of any fines or disciplinary action by any insurance or other regulatory authority? ..... ☐ Yes ☐ No

*If yes, attach an explanation.*

- b. Has any policy or application for professional liability insurance on behalf of the applicant or any of its past or present owners, officers, partners, employees or salespersons (whether employees or independent contractors), or to the knowledge of the applicant, on behalf of its predecessors in business, ever been declined, canceled or renewal refused within the past 10 years? **(Not applicable if domiciled in Missouri)**.... ☐ Yes ☐ No

*If yes, attach an explanation.*

- c. Have any professional liability claims been made against the applicant or any of its past or present owners, officers, partners, employees or salespersons (whether employees or independent contractors), or to the knowledge of the applicant, on behalf of any preceding business of yours, within the past 5 years? ..... ☐ Yes ☐ No

*If yes, please complete a Supplemental Claim Form for each claim.*

- d. Are there any circumstances with may result in professional liability claims being made against the applicant, past or present owners, officers, partners, employees, or salespersons (whether employees or independent contractors) or its predecessor in business?..... ☐ Yes ☐ No

*If yes, please complete a Supplemental Claim Form for each claim.*

**(Note: Claims already made or potential claims that you are aware of prior to the policy inception are not covered).**

## 7. Coverage Desired:

- 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
<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$1,000 (minimum)
<input type="checkbox"/> \$250,000/\$750,000	<input type="checkbox"/> \$2,500
<input type="checkbox"/> \$500,000/\$1,500,000	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$1,000,000/\$3,000,000	<input type="checkbox"/> \$7,500
<input type="checkbox"/> Other \$ _____	<input type="checkbox"/> \$10,000
	<input type="checkbox"/> Other \$ _____

- b. Optional Coverage:

Optional Coverage for Mutual Fund sales or Property and Casualty Insurance sales: Please indicate if coverage is 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. **IMPORTANT NOTE: Please include a sample of your stationery letterhead with this application.**

**ARKANSAS:** 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.

**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.

**DISTRICT OF COLUMBIA:** 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:** 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.

**HAWAII:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**KENTUCKY:** 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.

**LOUISIANA:** 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.

**MAINE:** 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.

**MINNESOTA:** A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NEW MEXICO:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**NEW YORK (Non Auto):** 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:** 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:** 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.

**OREGON:** Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

**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 THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

**PUERTO RICO FRAUD WARNING:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**TENNESSEE (Non WC):** 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.

**VERMONT:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

**VIRGINIA:** 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.

**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.

**WEST VIRGINIA:** 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.

**ALL OTHER STATES:** Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and civil penalties. Not applicable in Nebraska.

## 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 ( <i>Partner, Member, Officer, Proprietor</i> )	Title	Date
Print name	Name of Firm	

**Important Note:** 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.

**Please send completed forms to Marsh Affinity Group Services, P.O. Box 8146, Des Moines, IA 50301-8146, Telephone: 888-424-2310, Fax: 515-243-2331**