APPLICATION FOR PROFESSIONAL LIABILITY ERRORS & OMISSIONS INSURANCE

IF COVERAGE IS ISSUED, IT WILL BE ON A CLAIMS-MADE AND REPORTED BASIS

NOTICE: THIS INSURANCE COVERAGE PROVIDES THAT THE LIMIT OF LIABILITY AVAIALBLE TO PAY JUDGEMENT OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR LEGAL DEFENSE. FURTHER NOTE THAT AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE DEDUCTIBLE AMOUNT.

1. NAME OF APPLICANT: _____

   ADDRESS: _____

   CITY: _____ STATE: _____ Zipcode: _____

   WEBSITE ADDRESS: _____

2. LIMIT OF LIABILITY DESIRED

   $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ Other _____

3. DEDUCTIBLE

   $5,000 ☐ $10,000 ☐ $25,000 ☐ Other _____

4. Please describe in detail the professional activities for which coverage is desired:

_____
_____
_____
_____
_____
_____
_____
_____
_____

5. Is the applicant engaged in any business or profession other than as described in Item 4?

_____
_____

   If yes, please attach an explanation and estimated revenues.

6. List the total gross revenues for the past two years derived from those activities in Question 4. In addition, please list projected revenues for the current year.

YEAR	AMOUNT	
a) Current Projected	$ _____	*If revenues are over $10,000,000 or if deductible of $25,000 or higher are elected, please attach a copy of your most recent financial statements.
b) _____	$_____	
c) _____	$ _____	

6. d) In the last 12 months has the Insured had a positive Net Income? YES ☐ NO ☐

Positive Net Equity? YES ☐ NO ☐

If No, please provide details including remedial actions taken.

_____
_____
_____
_____
_____

7. For the revenues listed in question 6a), please give the approximate percentage derived from each of the activities listed in Question 4:

ACTIVITY	% OF 6a) REVENUES
_____	_____%
_____	_____%
_____	_____%
_____	_____%

8. Does the applicant Firm provide professional services to business entities in which it retains an ownership?

YES ☐ NO ☐ If yes, please explain

_____

_____

9. Year Established: _____

10. Is the Applicant Firm controlled, owned or associated with any other firm, corporation or company?

YES ☐ NO ☐ If yes, attach an explanation.

Are any activities listed in Question 4 provided to such business enterprise? YES ☐ NO ☐

11. a) Numbers of principals, partners, officers and professional employees directly engaged in providing services to clients: _____

b) Number of non-professional employees (clerks, secretaries, etc.): _____

12. Please provide the following:

Name in full of ALL Partners/Principals/ Key Employees	**PROFESSIONAL QUALIFICATIONS**	**DATE QUALIFIED**	**HOW LONG IN PRACTICE**	**HOW LONG AS PARTNER/ PRINCIPAL**

13. To what professional association(s) does the Applicant Firm belong?

_____

_____

14. Please include a list of Applicants Firm's five (5) largest jobs or projects during the past three (3) years. Please give, in detail: 1) project/client name; 2) the nature of the services performed for the client; and 3) the revenues obtained from those services.

_____
_____
_____

_____
_____
_____

_____
_____
_____

_____
_____
_____

_____
_____
_____

15. Does the Applicant Firm use a written contract with client?

☐ In all cases ☐ Sometimes ☐ Never

Please attach a copy of your standard contract(s).

16. Does the applicant use independent contractors? ☐ YES ☐ NO

If yes, please answer the following:

a. What percentage of the Applicant Firm's business involve subcontracting work to others? _____%.

b. What type of services are performed by independent contractors?

_____

_____

_____

c. Is proof that Independent Contractors carry professional liability required? ☐ YES ☐ NO

17. Has any similar insurance ever been declined or cancelled? ☐ YES (If yes, attach explanation) ☐ NO

18. a. Is similar insurance currently in force? ☐ YES ☐ NO
If yes, please provide:

Description of services being covered:

_____

_____

Name of Insurer:

_____

Expiration Date:

_____

Limit: $_____ Deductible $_____ Premium $_____

Length of time coverage has been in force: _____

18. b. Give the following information for General Liability Coverage in force:

Carrier: _____ Limit: $_____ Expiration Date: _____

19. Have any of the individuals listed in question No. 12 ever been the subject of disciplinary action by authorities as a result of their professional activities? ☐ YES ☐ NO If yes, please explain.

_____

_____

_____

_____

20. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her. ☐ YES ☐ NO

If yes, please complete a Supplemental Claim Information form for each.

21. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years?

☐ YES ☐ NO If yes, please complete a supplemental Claims Information form for each claim.

Also, how many claims have been made in the last five (5) years? _____

It is understood and agreed that with respect to questions 20, 21 and 22 above, that if such knowledge or information exists any claim or action arising therefrom is excluded from this proposed coverage.

NOTICE TO NEW YORK APPLICANTS: 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, WHICH IS A CRIME.

The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The Applicant hereby further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Signature of person authorized to execute on behalf of the Applicant:

_____

Title _____

Date_____

This Application Form duly completed, together with any supplementary information, must be signed by the person indicated.

Signing of this form does not bind the Applicant or the Underwriters to complete the insurance.

THIRD PARTY BENEFIT PLAN ADMINISTRATORS/CONSULTANTS
SUPPLEMENTAL APPLICATION

1. Give approximate percentage of revenues derived from all operations engaged in:

OPERATIONS	% OF PROJECTED REVENUES	IF COVERAGE IS DESIRED CHECK HERE
Providing Consulting Services	_____	☐
Providing Actuarial Services	_____	☐
Administration of Health & Welfare Plans (specify type)		
- Single Employer Plans	_____	☐
- Multiemployer Benefit Plans (Taft-Hartley Trusts)	_____	☐
- Mutiple Employer Welfare Arrangements (MEWAs)	_____	☐
Administration of Pension Plans	_____	
The design, development or customization of computer software sold or provided to third parties outside the normal operations of the applicant as a TPA	_____	☐
Other _____	_____	☐
Total must equal	100%	

2. a. Number of Plan sponsors: _____
   b. Number of participants for the Plans administered by the Applicant: _____
   c. Total annual contributions to the Plans administered by the Applicant: _____
   d. Total annual benefit payments issued in the Applicant's administration of all such plans: _____
   e. Number of Plan Sponsors added and deleted in the past year: _____
   f. What percentage of all Plans are:
      - Self funded with stop-loss? _____%
      - Self funded with no stop-loss? _____%
      - Fully insured? _____%
   g. List carriers that stop-loss coverages are placed with:
      _____
      _____
      _____
      _____

3. Does the applicant firm, its partners, directors, officers or employees act as trustee for the Employee Benefit Plans clients or non clients? ☐ YES ☐ NO

4. a. Name and address of law firm(s) acting as counsel to the applicant firm and nature of services provided: _____
_____
_____

   b. Name and address of all firms providing accounting services to the applicant and the nature of services provided: _____
_____
_____

5. Does the applicant have a fidelity bond? ☐ YES ☐ NO
If NO, do your clients list you as an additional insured under their Fidelity coverage? ☐ YES ☐ NO

6. Please outline below the applicant firm's standards of practice (procedural protocols).

   a. Do you have written guidelines for the administration of each of your Plans, including your procedure for denial of benefits? ☐ YES ☐ NO
   b. What percentage of claims are denied? _____%
   c. What percentage of denials are appealed? _____%
   d. What is the average error rate of your claims handlers? _____%

7. a. Which of the following are function of your firm's Electronic Data Processing System? (Please check all that apply)

☐ Calculation of Co-payments
☐ Claim Eligibility
☐ Enrollment Information
☐ Management Reports
☐ Adjustors Accuracy
☐ Analysis of Large Claims
☐ Notices to Stop-Loss Carriers
☐ Productivity Reports
☐ Claim payments by Plan Year
☐ Telephone Tracking System
☐ Total Calls Received
☐ Call backs due to claim handling problems
☐ Turn around time
☐ Calculation of Deductibles
☐ Confidentiality Safeguards
☐ Monitoring of Duplicate Claims
☐ Claim Appeals tracking
☐ Check Registers (weekly & monthly)
☐ Payment Registers and analysis
☐ Monthly Aggregation Reports to Carrier (by claim or agg & spec)
☐ Claim analysis summaries by Year
☐ Time & materials analysis
☐ Cost containment results
☐ Expense analysis
☐ Analysis of Loss causes

   b. If your system contains checks and balances to guard against the following, please note them with a check-mark:

☐ Overpayments ☐ Underpayments

☐ Late Payments
☐ Payments to incligiblcs
☐ Improper refusal of benefits

☐ Payments from incorrect Plan
☐ Unfair/unjust cnrichmcnt
☐ Failure to follow payment guidelines or procedures.

8. How often does your organization do an internal audit? _____
_____

What situations are the audit guidelines designed to reveal? _____
_____
_____
_____

9. What is your average turnaround time for benefits claim processing?
This year: _____ days Last year: _____ days

It is understood and agreed that this supplemental application shall become part of the application for Professional Liability Errors & Omissions Insurance.

_____ Date

_____ Name of Applicant

_____ Signature of person authorized to execute on behalf of the Applicant

MPL SA23