

# Carolina Casualty Insurance Company

4600 Touchton Road East, Building 100, Suite 400, Jacksonville, FL 32246

Proposal Form

## Lawyers' Professional Liability Insurance

### CLAIMS MADE WARNING FOR APPLICATION

**THIS PROPOSAL FORM IS FOR A CLAIMS MADE AND REPORTED POLICY, RELATING TO CLAIMS MADE AGAINST THE INSUREDS DURING THE POLICY PERIOD, THE AUTOMATIC EXTENDED REPORTING PERIOD OR THE PURCHASED EXTENDED REPORTING PERIOD, IF APPLICABLE.**

Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the Policy. This Proposal Form is to be completed with respect to the entire Applicant Firm.

Name of Applicant Firm \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

The person designated as agent of the Applicant Firm and of all Insureds to receive any and all notices from the Insurer or their authorized representatives concerning this insurance:

Name \_\_\_\_\_

Title \_\_\_\_\_

E-mail Address \_\_\_\_\_

### General Information

1. Check the box that describes the above Applicant Firm.
- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Partnership     | <input type="checkbox"/> Professional Association | <input type="checkbox"/> Limited Liability Corporation | <input type="checkbox"/> Limited Liability Partnership |
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Professional Corporation |  |  |

If you are a sole proprietor, provide the name of the lawyer(s) who would be responsible for your affairs if you were absent for an extended period of time (i.e., vacation, illness, etc).

Name: \_\_\_\_\_

Address (City, State, Zip): \_\_\_\_\_

Telephone Number: \_\_\_\_\_

2. Date Commenced Business: \_\_\_\_\_

3. List the names of all **Predecessor Firms** to whose assets and liabilities the Applicant Firm is the majority successor in interest. Include the date the **Predecessor Firms** were established and the dates of merger.

Name of Predecessor Firm	Date Established	Date of Merger

4. Indicate the total number of personnel by location.

	Principal Office	Branch Office (a)	Branch Office (b)	Branch Office (c)
Total number of lawyers				
Paralegals or law clerks				
Other clerical/support staff				

Complete the Individual Insured Supplemental Form (LPL 29600).

5. Does any lawyer in the Applicant Firm serve as a director, officer, trustee or partner of, or exercise any fiduciary control over, any organization other than the Applicant Firm?  Yes  No

If "Yes", complete the following.

Name of Lawyer	Name of Organization	Is Organization For Profit or Non—Profit?	Is the Organization a Firm Client?	Position Held by Lawyer	Percentage of Equity Held	Percentage of Total Firm Billings
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			<input type="checkbox"/> Yes <input type="checkbox"/> No			

# Carolina Casualty Insurance Company

## Nature of Practice

6. Indicate the gross income for the applicable fiscal year (gross income means all sums billed to clients for services rendered, or if your Applicant Firm deals primarily with contingency fee cases, your average annual gross revenue):

Actual for immediate past fiscal year:

\$ \_\_\_\_\_

7. Indicate the percentage of gross income for the past fiscal year derived from the following areas of practice:

<u>Area of Practice</u>	<u>%</u>	<u>Area of Practice</u>	<u>%</u>
Administrative Law - General	_____ %	Insurance Coverage	_____ %
Admiralty/Maritime	_____ %	Insurance Defense Litigation	_____ %
Antitrust/Trade Regulation	_____ %	International Law	_____ %
Arbitration/Mediation	_____ %	Labor Relations - Labor	_____ %
Bankruptcy	_____ %	Labor Relations - Management	_____ %
Banks/Savings and Loans	_____ %	Litigation (Civil)	_____ %
Civil Rights and Discrimination	_____ %	Local Government Law – without bonds	_____ %
Collection/Repossession	_____ %	Mergers and Acquisitions	_____ %
Commercial Law	_____ %	Oil and Gas	_____ %
Commercial Litigation – Defense	_____ %	Pension and Employee Benefits	_____ %
Commercial Litigation - Plaintiff	_____ %	Personal Injury and Negligence Litigation - Defense	_____ %
Communications (FCC)	_____ %	Personal Injury and Negligence Litigation - Plaintiff	_____ %
Construction Law	_____ %	Public Contract Law	_____ %
Copyright/Patent/Trademark	_____ %	Public Utilities	_____ %
Corporate Organization/Formation	_____ %	Real Property - Conveyance	_____ %
Criminal Law	_____ %	Real Property - Development	_____ %
Entertainment/Sports – with Money Management	_____ %	Real Property - Title Examination	_____ %
Entertainment/Sports – without Money Management	_____ %	Securities Law – including municipal bonds	_____ %
Environmental Law	_____ %	Taxation - Opinions	_____ %
Estate, Trust and Probate	_____ %	Taxation - Preparation	_____ %
Family Law	_____ %	Workers' Compensation Litigation - Plaintiff	_____ %
General Corporate/Business	_____ %	Workers' Compensation Litigation - Defense	_____ %
Healthcare	_____ %	Other (list):	_____ %
Immigration and Naturalization	_____ %		_____ %
		<b>TOTAL</b>	<b>100%</b>

8. Indicate the percentage of the Applicant Firm's plaintiff cases that are class actions suits.

\_\_\_\_\_ %

## General Policy and Procedures

9. Docket and Calendar Procedures:

- (a) Does the Applicant Firm maintain a planned docket control system and procedure with at least 2 independent date controls?  Yes  No
- (b) Are the docket control system(s) and the procedure computerized?  Yes  No

10. Business Procedures:

- (a) Does the Applicant Firm use engagement/disengagement/non-engagement letters?  Yes  No
- (b) Does the Applicant Firm maintain a system to avoid conflicts of interest?  Yes  No
- (c) Is the conflicts system computerized?  Yes  No
- (d) How many suits for collection of fees have been filed by the Applicant Firm during the past 2 years? \_\_\_\_\_
- (e) How many lawyers of the Applicant Firm have participated in formal continuing legal education programs, of at least 7 hours, during the last year? \_\_\_\_\_
- (f) Does the Applicant Firm share office space, expenses, cases, or letterhead with any other individual, of counsel, partnership, firm, or organization? If "Yes", provide, on separate attachment, the name of the entity(ies).  Yes  No

**Carolina Casualty Insurance Company**

**Prior Insurance Information**

11. Has the Applicant Firm or any predecessor in business ever had an insurer decline, cancel, refuse to renew, rescind, or accept only on special terms, any professional liability insurance? (Not applicable in Missouri)  Yes  No  
 If "Yes", provide full details. \_\_\_\_\_

12. Has the Applicant Firm or any predecessor in business ever purchased an "Extended Reporting Period" or "Discovery Period" under a prior policy which extended the claims reporting period of the policy following cancellation or non-renewal?  Yes  No  
 If "Yes", provide full details. \_\_\_\_\_

13. List the professional liability insurance purchased by the Applicant Firm for each of the past 5 years.

Insurer	Limit of Liability	Deductible	Premium	From Mo/Day/Yr	To Mo/Day/Yr

14. Does the Applicant Firm's current or most recently expired policy contain a retroactive date?  Yes  No  
 If "Yes", indicate the date: \_\_\_\_\_ (Mo/Day/Yr)

**Litigation and Claim Information**

15. Has any lawyer in the Applicant Firm ever been refused admission to practice, disbarred, or suspended from practice, reprimanded, sanctioned, or disciplined by any court or administrative agency?  Yes  No  
 If "Yes", provide full details. \_\_\_\_\_

16. During the last 5 years, has any professional liability claim or suit been made against the Applicant Firm, or any predecessor in business, or any past or present lawyers in the Applicant Firm?  Yes  No  
 If "Yes", provide full details on the Claim / Incident Supplemental Form (LPL 29610).

17. Is the Applicant Firm or any lawyer in the Applicant Firm aware of any fact, circumstance, or situation that might result in any professional liability claim or suit against the Applicant Firm, or any predecessor in business, or any past or present lawyers in the Applicant Firm?  Yes  No  
 If "Yes", provide full details on the Claim / Incident Supplemental Form (LPL 29610).

**IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR DAMAGES OR CLAIMS EXPENSE IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON, ARISING OUT OF, DIRECTLY OR INDIRECTLY RESULTING FROM OR IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY PROFESSIONAL LIABILITY CLAIM OR SUIT, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH IN RESPONSE TO QUESTIONS 16. OR 17.**

# Carolina Casualty Insurance Company

## Please Read Carefully

The undersigned acting on behalf of the Applicant Firm and all persons proposed for this insurance declares that the statements set forth herein are true and correct and that thorough efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Proposal Form.

The undersigned agrees that the particulars and statements contained in the Proposal Form and any material submitted herewith are their representations and that they are material and are the basis of the insurance contract. The undersigned further agree that the Proposal Form shall be considered attached to and a part of the Policy. Any material submitted with the Proposal Form shall be maintained on file with the **Insurer** and shall be deemed to be attached hereto as if physically attached.

It is further agreed that:

- if any significant change in the condition of the applicant is discovered between the date of this Proposal Form and the Policy inception date, which would render this Proposal Form inaccurate or incomplete, notice of such change will be reported in writing to the **Insurer** immediately;
- any Policy, if issued, will be in reliance upon the truth of such representations;
- this Proposal Form has been completed as respects the entire Applicant Firm;
- and the signing of this Proposal Form does not bind the undersigned to purchase the insurance.

	Title:
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Partner, Owner, Officer or Principal

	Dated:
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Print Name

This Carolina Casualty Insurance Company Proposal Form, including any material submitted herewith, shall be held in strictest confidence.

**A POLICY CANNOT BE ISSUED UNLESS THE PROPOSAL FORM IS PROPERLY SIGNED AND DATED.**

Please submit this Proposal Form including appropriate documentation to:  
Monitor Liability Managers, Inc., 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039

	Dated:
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Submitted by (PRODUCER)

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AGENT'S NAME (Please Print Name Here)

AGENT'S LICENSE NUMBER

## **Carolina Casualty Insurance Company**

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**NOTICE TO COLORADO APPLICANTS:** 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

**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 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.

**NOTICE TO NEW MEXICO, PENNSYLVANIA APPLICANTS:** 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.

**NOTICE TO APPLICANTS OF KENTUCKY:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A CRIME AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO APPLICANTS OF FLORIDA, MINNESOTA, NEW JERSEY, OHIO, AND OKLAHOMA:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO DISTRICT OF COLUMBIA, MASSACHUSETTS, TENNESSEE, AND VIRGINIA APPLICANTS:** 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.

**NOTICE TO MAINE APPLICANTS:** 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 OR DENIAL OF INSURANCE BENEFITS.

Lawyers' Professional Liability Insurance

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Whenever printed in this Proposal Form, the terms in boldface type shall have the same meanings as indicated in the Policy.

1. Name of Applicant Firm

APPLICANT FIRM'S INSTRUCTIONS

COMPLETE ONE FORM FOR EACH CLAIM, SUIT, OR CIRCUMSTANCE DURING THE LAST 5 YEARS. IF SPACE IS INSUFFICIENT TO ANSWER ANY QUESTIONS FULLY, PROVIDE SEPARATE ATTACHMENTS.

2. Full name of individual(s) and firm involved in the Claim, suit, or circumstance which could give rise to a Claim:

Full name(s) of Claimant (Plaintiff):

(a) \_\_\_\_\_

(b) \_\_\_\_\_

Full name(s) of Defendant:

(a) \_\_\_\_\_

(b) \_\_\_\_\_

Additional Defendant(s):

(a) \_\_\_\_\_

(b) \_\_\_\_\_

3. Date alleged Claim, suit, or circumstance occurred: \_\_\_\_\_

4. Date Claim made against an Insured: \_\_\_\_\_

5. Location of Claim (City, State): \_\_\_\_\_

6. Has this Claim, suit, or circumstance been reported to any insurance carrier? \_\_\_\_\_

Yes  No

If "Yes", date reported to insurance company: \_\_\_\_\_

7. To which insurance company did you report this Claim, suit, or circumstance? \_\_\_\_\_

8. Current status of Claim, suit, or circumstance (circle one): Closed  Open  In Suit  Potential

9. If Claim, suit, or circumstance is Closed, provide the following:

(a) Total damages paid: \$ \_\_\_\_\_ (b) Total expenses paid (including deductible): \$ \_\_\_\_\_

(TOTAL DAMAGES PAID AND TOTAL EXPENSES PAID MUST BE PROVIDED.)

10. If Claim, suit, or circumstance is Open, In Suit, or Potential, provide the following:

(a) Total damages demanded: \$ \_\_\_\_\_ (b) Total expenses paid to date: \$ \_\_\_\_\_

(PAID EXPENSE AMOUNT MUST BE PROVIDED. CONTACT YOUR AGENT, INSURANCE COMPANY, OR DEFENSE COUNSEL TO OBTAIN THE REQUIRED INFORMATION.)

11. (a) What specific causes of action are alleged in the Claim, suit, or circumstance? (Provide enough information to allow for an evaluation.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) Description of events that gave rise to the Claim, suit, or circumstance.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(c) Explain what actions the Applicant Firm has taken to prevent a recurrence or similar claim / incident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Carolina Casualty Insurance Company

I understand that the information submitted herein becomes a part of the Applicant Firm's Lawyers' Professional Liability Proposal Form and is subject to the same representations and conditions.

	Title:
--	--------

Signature of Partner, Owner, Officer or Principal

	Dated:
--	--------

Print Name

Please submit this Proposal Form including appropriate documentation to:

Monitor Liability Managers, Inc., 2850 West Golf Road, Suite 800, Rolling Meadows, IL 60008-4039

	Dated:
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Submitted by (PRODUCER)

--	--

AGENT'S NAME (Print Name Here)

AGENT'S LICENSE NUMBER

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9201 Forest Hill Ave., Suite 200, Richmond, VA 23235 Phone: (800) 577-6614 Fax: (804) 327-3172

EMPLOYED COUNSEL
ERRORS & OMISSIONS APPLICATION

APPLICANT'S INFORMATION:

Form with fields for NAME OF EMPLOYER, PRINCIPAL BUSINESS PREMISE ADDRESS, YEAR EMPLOYER ESTABLISHED, and checkboxes for Corporation, Individual, Partnership, PA/PC, Franchise.

APPLICANT'S OPERATIONS:

1. What is the nature of business for the Employer? \_\_\_\_\_

(If employer is an insurance company or agency, then complete the Insurance Company Supplement.)

2. Briefly describe the duties and responsibilities handled by employed attorneys: \_\_\_\_\_

3. Indicate below the approximate percentage of legal work undertaken by the legal department on behalf of the Employer as is devoted to:

Table with 3 columns of legal categories and their percentages, including Admiralty/Maritime, Domestic Relations, Real Estate, etc.

\*Complete Securities Supplement.

\*\*General practice is not acceptable.

\*\*Over 5% Other – provide full details.

4. Number of Employed: Law Clerks \_\_\_\_\_, Investigators \_\_\_\_\_, Abstractors \_\_\_\_\_, Paralegal Personnel \_\_\_\_\_, Clerical Staff \_\_\_\_\_, Attorneys \_\_\_\_\_.

5. Is any lawyer employed by any entity other than the Employer listed under Applicant's Information above? [ ] Yes [ ] No. If Yes, please explain: \_\_\_\_\_

6. Is any employed attorney also serving as an officer or director to the Employer? [ ] Yes [ ] No



**INSURANCE HISTORY:**

1. Current Insurer \_\_\_\_\_ Deductible \$ \_\_\_\_\_  
 Limits of Liability: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
 Expiring Premium \$ \_\_\_\_\_ Is Current Carrier willing to Renew?  No  Yes  
 Retroactive Date (Prior Acts) \_\_\_\_\_ (Please attach copy of Declaration Page)

2. Requested Limits:  \$100,000/\$300,000  \$500,000/\$500,000  
 \$300,000/\$600,000  \$1,000,000/\$1,000,000  
 Requested Deductible (Per Claim):  \$1,000  \$5,000  \$2,500  \$10,000

3. List similar professional liability insurance carried for the past five years. If none, state none.

Inception	Expiration	Insurance Co.	Policy Number	Limits of Liability	Deductible (If any)
From _____	To _____	_____	_____	_____	_____
From _____	To _____	_____	_____	_____	_____
From _____	To _____	_____	_____	_____	_____
From _____	To _____	_____	_____	_____	_____
From _____	To _____	_____	_____	_____	_____

4. Based on inquiry of each employed lawyer, has any lawyer ever had any insurance company or Lloyd's decline, cancel, refuse to renew or accept only on special terms any professional liability insurance?  
 Yes  No. If Yes, please provide the names of the lawyers and brief explanation. \_\_\_\_\_

5. Based on inquiry of each employed lawyer, has any lawyer ever been the subject of reprimand or disciplinary action or refused admission to the bar association, court or administrative agency as a result of professional activities?  
 Yes  No. If Yes, please provide the name of the lawyer and brief explanation. \_\_\_\_\_

6. Based on inquiry of each employed lawyer, has any professional liability claim or suit ever been made against any lawyer?  
 Yes  No. If Yes, please give full details on a Supplemental Claim Information Form.

7. Based on inquiry, does the Employer or employed lawyer know of any circumstance, act, error or omission that could result in a professional liability claim against any employed lawyer?  
 Yes  No. If yes, please give full details on a Supplemental Claim Information form.

**ADDITIONAL INFORMATION:**

Please attach the following:

- a. Any secondary locations of Employer.
- b. Most recent 10k report and brochure of services provided.
- c. Completed attached Supplement for EACH ATTORNEY.
- d. If Employer is Insurance Company/Agency, completed Insurance Company Supplement.

\* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

\* not applicable in all states

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_  
Name of Applicant Title

\_\_\_\_\_  
Applicant's Signature Date

NOTE: SIGNING THIS FORM DOES NOT BIND THE APPLICANT, THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.