ADMIRAL INSURANCE COMPANY
1255 Caldwell Road
Cherry Hill, NJ 08034
Phone: 856-429-9200 Fax: 856-429-8611
Internet: http://www.admiralins.com

CLAIMS ADJUSTERS
SUPPLEMENT
to Miscellaneous Professional Liability Application

1. Please complete the following sections showing the approximate percentages of your total operations involving:
   a. _____% Insurance Company Adjusting b. _____% Self-Insured Adjusting
   c. _____% Public Adjusting

2. Indicate the approximate percentages of your total revenue derived from adjusting the following lines of insurance:
   a. _____% Auto Physical Damage f. _____% Products Liability
   b. _____% Auto Liability g. _____% Professional Liability
   c. _____% Aviation Liability h. _____% Property (Fire & Allied Lines)
   d. _____% Life Insurance i. _____% Workers' Compensation
   e. _____% Premises/slip & fall, etc.

   j. _____% Other: (describe) _____
   Total: 100 %

3. What percentage of your adjusting services involve:
   Personal Lines business? _____% Commercial Lines business? _____%

4. Does your firm provide any services to preferred provider or health maintenance organizations? □ Yes □ No
   If "Yes," please provide detail by separate attachment.

5. Does your firm own or have affiliation with an insurance agency or insurance brokerage? □ Yes □ No
   If "Yes," please provide the names of those agencies and/or brokerages.

   _____

   _____

   _____

   A. Does the firm, or any owner or officers of the firm own, engage in, operate, manage or act as a director or officer of any other business? □ Yes □ No **If Yes, please provide details by attachment.**

6. Do you have authority to settle on behalf of your client/carrier? □ Yes □ No
   If "Yes," what is your authority limit? $_____

7. Do you have authority to deny claims on behalf of your client/carrier? □ Yes □ No

8. For claims handled, what is the average claim value during the past 12 months? $_____
   Largest claim value during the past 12 months? $_____

9. Do you offer any services other than claims adjusting? □ Yes □ No **If Yes, please provide details by separate attachment.**

10. Please check each category where you have controls in place to guard against:
    [] Overpayments [] Underpayments [] Late Payments
    [] Payments to incorrect plan [] Payments to ineligibles [] Unfair/unjust enrichment
    [] Improper refusal of benefits [] Failure to follow payment guidelines or procedures

11. Describe all steps to keep client information confidential:

    _____

    _____

12. Are all transactions between the adjuster, the insurance company, the insured and others carefully documented?
☐ Yes ☐ No **If "No,"** please explain why not: _____

13. What is the average length of time a typical claim file remains open? _____

14. What number of files are handled per adjuster per week? _____

15. Does the Applicant utilize Structured Settlement Plans? ☐ Yes ☐ No
If "Yes," what percentage of settlements are Structured Settlement Plans? _____%

16. List all states where you adjusted claims during the past 12 months: _____

_____

A. List any additional states where you will be adjusting claims during the next 12 months: _____

_____

B. Are licensing requirements met in all states where the applicant firm adjusts claims? ☐ Yes ☐ No

17. For all states where you may adjust claims, please describe the training & steps taken to ensure compliance with applicable Unfair Claims Practices Acts state laws. **Please include this on separate attachment.**

18. Within the past five years, has the firm performed any professional services for any client in which any shareholder, officer or employee of the firm had any ownership interest, or which he/she controlled, operated or managed to any extent?

Client Name	Type of Business	Ownership %	Capacity	Dates of work	% of annual revenue

19. What percentage of applicant's business involves subcontracting work to others? _____%
Cost of subcontracted work _____ What operations are subcontracted? _____
Are sub-contractors required to carry their own E&O insurance? ☐ Yes ☐ No
If "Yes," what minimum limits are required of sub-contractors? _____

20. Individuals – Please list all owner(s), partners, officers, and employees engaged in professional services. Include part-time employees and all professional staff members.

Name	Title	Years of claims examining experience

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this Supplemental Information Sheet shall be in addition to the information contained in the application and will be made a part of the policy.

Date: _____

Signature: _____

Title: _____
(Owner, Partner, Authorized Officer)

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APPLICATION FOR MISCELLANEOUS PROFESSIONAL LIABILITY INSURANCE (CLAIMS MADE FORM)

1. Name of Applicant :_____

   Address:_____
   Street **City/State** **Zip**

   a. Other entities to be considered as Insured? Yes [ ] No [ ]
   If Yes, by separate attachment provide name, relationship to Applicant, operations description and revenue.

   b. Other locations? Yes [ ] No [ ] **If Yes, by separate attachment please provide addresses.**

   Applicant's Website Address:_____Telephone #:(_____)_____

2. Applicant is:[ ] Individual [ ] Partnership [ ] Corporation [ ] LLC [ ] Non-Profit Organization Other:_____
   a. If LLC, please provide members names and ownership %:
   _____
   _____

3. Date Firm Established _____**(mm/dd/yy)**

4. Has the name of the firm ever changed? Has there ever been any acquisitions, consolidations, dissolution or merger? Yes [ ] No [ ] If yes, please explain.
   _____
   _____

5. Is the firm engaged in, owned by, associated with or controlled by any other business? Yes [ ] No [ ]
   If Yes, please explain.
   _____
   _____

PROFESSIONAL SERVICES AND SPECIALITY (attach narrative description if necessary).

6. A. Describe in detail the professional services for which coverage is desired and indicate the % of gross receipts/revenue derived from each activity:
   _____
   _____
   _____
   _____
   _____
   _____

   B. Gross Annual Receipts/Revenue: Next Year/ 20___ $_____
   This Year /20___ $_____
   Last Year/20___ $_____

   C. **Please include by attachment to this application:**
   1. 5 largest clients and description of services performed for each, and revenue
   2. Resumes of professionals
   3. Association/Memberships, Licenses or Certifications, Brochures/Advertisements
   4. Sample contract between Applicant and their client
   5. Most current Financial data (Annual Report or Balance Sheet)

7. Total number of employees_____
   Partners/Officers: _____ Administrative/Clerical: _____
   Professional/Technical: _____ Other_____ _____

8. Is Applicant engaged in any business/profession other than as stated in question 6.? Yes [ ] No [ ]
If Yes, please provide details by separate attachment.

9. Does Applicant contemplate any change in services or emphasis planned for the next 12 months?
Yes [ ] No [ ] **If Yes, please provide details by separate attachment.**

10. Please explain what type of claim or allegations could the Applicant be involved in?

_____

_____

11. **PROFESSIONAL LIABILITY COVERAGE FOR LAST 5 YEARS (if NONE check here [ ])**

CARRIER	LIMIT **(per claim/agg)**	DEDUCTIBLE	PREMIUM	EXPIRATION **(mm/dd/yy)**

12. What is the **retroactive date** of expiring Professional Liability policy?_____**(mm/dd/yy).**

13. Has any insurer cancelled/refused to renew any similar coverage during the last 5 years? Yes [ ] No [ ]
If Yes, please provide details on separate attachment .

14. Has any professional liability claim or suit been made against Applicant, any predecessor in business or against any past or present partner/officer(s)? Yes [ ] No [ ] **If Yes, please provide on separate attachment these details – allegations, amount of damages/demand, date of loss/date claim made/reserve amounts for indemnity and expenses as well as paid amounts for indemnity and expenses.**

15. Is the Applicant aware of any circumstance or incident which may result in any claim against them or any predecessor in business or any past or present partner/officer? Yes [ ] No [ ]
If Yes, please provide details on separate attachment.

The Applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell no the Applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made part of the policy.

The Applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

_____ _____

Signature of Applicant **Date**

_____

Title (Officer/Principal/Partner)