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 CONCERING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

PROFESSIONAL LIABILITY DISCOVERY QUESTIONNAIRE

THIS IS FOR QUOTATION PURPOSES ONLY – THIS IS NOT A BINDER

PROPOSED EFFECTIVE DATE: _____

General Information

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: ( )_____ Fax: ( )_____

Physical Location of Business (if different): _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Detailed description of business activities (specifically, and by location): _____

_____

Is this a new business? **o** Yes **o** No If no, how many years have you been in business? _____

Applicant is: **o** Individual **o** Corporation **o** Partnership **o** Joint Venture

o Other (please describe): _____

Annual Payroll: $ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? **o** Yes **o** No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: ( )_____

Fax: ( )_____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			

Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor or related person or entity ever had a claim? **o** Yes **o** No

Completed Claims and Loss History form attached (REQUIRED)? **o** Yes **o** No

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?

o Yes **o** No

If the standard markets are declining placement, please explain why: _____

_____

2. Desired Insurance

Limit of Liability:

- **o** $100,000 per accident / $300,000 aggregate
- **o** $200,000 per accident / $300,000 aggregate
- **o** $250,000 per accident / $500,000 aggregate
- **o** $250,000 per accident / $1,000,000 aggregate

Identify all contracted medical professional services performed for you and the minimum medical professional liability limits required.

Pharmacy $_____

Respiratory Therapy $_____

Physical Therapy $_____

Other $_____

Self-Insured Retention (SIR): **o** $1,000 (Minimum) **o** $1,500 **o** $2,500 **o** $5,000 **o** $10,000

3. Business Activities

1. Annual Gross Income: $_____
2. Person providing accounting and tax services:
   a. Name: _____
   b. Address: _____
3. What sort of instruction have you had in regards to this profession?_____

   _____

   _____
4. Are you seeking:
   a. Insurance to cover work done exclusively by you? **o** Yes **o** No
   b. Insurance to cover work done by others under your direction? **o** Yes **o** No
   c. Insurance to cover the actions of individuals on your payroll? **o** Yes **o** No
5. Employee breakdown—please enter the number of:

	Full-Time	Part-Time
Operational Staff		
Non-Operational employees (drivers, collectors, supervisors, etc.)		

6. Describe in detail the regular operations and services you provide: _____

   _____

7. Describe the types of claims that are commonly made in your field of expertise: _____

8. Provide names of any partners or principal owners involved in the business:

TITLE	NAME	YEARS WITH THE FIRM	YEARS OF EXPERIENCE

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer’s accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant’s facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____
Applicant:

_____
Signature

_____
Print Name