



\_\_\_\_\_ (Agency Name) agrees to participate in the Secured Advantage E&O Group master policy underwritten through the Big "I" RPG E&O Alliance program with an effective date of 11/1/2018.

Please indicate your limit and deductible below:

Expiring limit:

\_\_\_\_\_

Other: Indicate if you need an optional higher limit quote

Expiring deductible:

\_\_\_\_\_

Date: \_\_\_\_\_

Agency Principal Name \_\_\_\_\_

Agency Principal Signature \_\_\_\_\_

Items needed to bind coverage:

- Completed short form application (Application is embedded in this document, please click to open)
- 5 year currently valued E&O loss runs (unless a current Westport policyholder, then no loss runs required)
  - If OIA currently handles your E&O insurance, we will pull the loss history for you

# First Specialty Insurance Corporation

## INDEPENDENT FRANCHISEE APPLICATION FOR "CLAIMS MADE" INSURANCE POLICY FOR INSURANCE AGENCY PROFESSIONAL LIABILITY (E&O)

**NEW BUSINESS:** Please provide 5-year loss runs and completed application along with all applicable supplements.

1. a. Agency's **Legal Entity** Name: \_\_\_\_\_

b. Organization Type:  Individual  Partnership  Corporation  LLC  Other: \_\_\_\_\_

c. Federal Employer/Tax ID No.: \_\_\_\_\_

d. Is the agency a member of the state independent insurance agents' association? .....  Yes  No

**If Yes**, provide agency active directory ID No.: \_\_\_\_\_

e. Date entity established\*: \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)

**\*If less than 3 years, attach resume and business plan**

f. Is coverage requested for any PREDECESSOR AGENCY\*? .....  Yes  No

\*A PREDECESSOR AGENCY is an agency to whose financial assets and liabilities your current agency is a majority successor in interest.

**If Yes**, provide:

Name of the PREDECESSOR AGENCY: \_\_\_\_\_

Date of Sale: \_\_\_\_\_

If the sale occurred within the past 5 years, please provide the following information about the PREDECESSOR AGENCY'S prior professional liability insurance. (✓ if "None" )

Name of Carrier	Expiration Date	Limit Each Claim	Deductible Each Claim	Premium	Policy Retro Date (if "Full Prior Acts", ✓ box)
	/ /	\$	\$	\$	/ / <input type="checkbox"/>
	/ /	\$	\$	\$	/ / <input type="checkbox"/>

**Note:** Questions 4-8 of this application must be answered with regard to any PREDECESSOR AGENCY (in addition to the Franchisee Agency) whether or not coverage is requested for such agency.

2. a. **Street Address** (Primary Location): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

b. **Mailing Address** (if different from 2.a.): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_

c. (1) Additional locations? .....  Yes  No

**If Yes**, number of additional locations?  1  2  3  4 or more?

(2) Any locations outside your primary state of domicile? .....  Yes  No

3. Office Procedures for all locations:

		Yes	No
a. Are incoming documents date-identified?		<input type="checkbox"/>	<input type="checkbox"/>
b. Does the agency maintain a policy expiration list?		<input type="checkbox"/>	<input type="checkbox"/>
c. Is there a procedure to use a coverage checklist on commercial proposals?		<input type="checkbox"/>	<input type="checkbox"/>
d. Is there a procedure to maintain written documentation of all rejections of coverage?		<input type="checkbox"/>	<input type="checkbox"/>
e. Is there a procedure to periodically review renewal risks for needed changes in coverage?		<input type="checkbox"/>	<input type="checkbox"/>
f. Is there a procedure to document that policies and endorsements are checked for accuracy prior to delivery?		<input type="checkbox"/>	<input type="checkbox"/>
g. Is there a procedure for documenting telephone conversations?		<input type="checkbox"/>	<input type="checkbox"/>
h. Does agency use a diary/suspense/follow-up procedure? If Yes, confirm type: <input type="checkbox"/> Automated Procedure <input type="checkbox"/> Non-Automated Procedure		<input type="checkbox"/>	<input type="checkbox"/>
i. Does applicant have a specific orientation program for new employees?		<input type="checkbox"/>	<input type="checkbox"/>
j. If multiple office locations, do all locations use a centralized agency management system?	<input type="checkbox"/> n/a	<input type="checkbox"/>	<input type="checkbox"/>
k. If multiple office locations, do all locations use same workflow procedures?	<input type="checkbox"/> n/a	<input type="checkbox"/>	<input type="checkbox"/>
l. Do you encrypt or use other measures to protect personal data when transmitted?		<input type="checkbox"/>	<input type="checkbox"/>

4. **Potential claims:** If this is a new business application, after inquiry of each agency personnel, are there any known circumstances or incidents which may result in a breach of privacy claim or an errors and omissions claim being made against the agency and/or the agency's personnel? .....  n/a  Yes  No

**If Yes, complete a Claim Supplement for each potential claim.**

5. **Actual claims:** Have any breach of privacy claims or errors and omissions claims or incidents been made against the agency or any of its past or present personnel or predecessor agency, within the last 5 years? .....  Yes  No

**If Yes, what is the total number of these claims not previously reported to First Specialty?** \_\_\_\_\_

**Complete a Claim Supplement for each claim/incident.** (Claim supplement not required for claims or incidents previously reported to First Specialty Insurance Corporation's Claims Dept.)

6. Has the agency paid an uninsured loss out of agency funds within the last 5 years? .....  Yes  No

**If Yes, what is the total number of losses?** \_\_\_\_\_

**Complete a Claim Supplement for each incident.** (Claim supplement not required for claims or incidents previously reported to First Specialty Insurance Corporation's Claims Dept.)

7. Has any policy or application for Errors and Omissions insurance on behalf of the applicant or any of its past or present owners, officers, partners or employees or solicitors, or to the knowledge of the applicant, on behalf of its predecessors in business, ever been declined, canceled or renewal refused within the last 5 years? .....  Yes  No

**If Yes, please indicate: Year(s):** \_\_\_\_\_

**Reason:**  Claim Experience  Carrier Withdrew From Market  Agency Operations  Non-Payment

Other (Describe): \_\_\_\_\_

8. In the last 5 years, have any past or present agency personnel been the subject of complaints filed, investigations and/or disciplinary action by any insurance or other regulatory authority or convicted of a criminal activity? .....  Yes  No

**If Yes, provide a copy of the action pending or taken by the disciplinary body or judicial system.**

## NOTICE TO APPLICANT

I hereby authorize the release of claim information from any prior insurer to us.

I understand and accept that the policy applied for provides coverage on a claims-made basis for only those claims that are made against the insured while the policy is in force and that coverage ceases with the termination of the policy. All claims will be excluded that result from any acts, circumstances or situations known prior to the inception of coverage being applied for, that could reasonably be expected to result in a claim.

For your protection, the following Fraud Warnings are required to appear on this application.

### **Applicable in 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.

### **Applicable in 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

### **Applicable in District of Columbia**

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.

### **Applicable in 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.

### **Applicable in 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.

### **Applicable in 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.

### **Applicable in 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.

### **Applicable to 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.

### **Applicable to 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.

### **Applicable to 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.

### **Applicable in Oklahoma**

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.

### **Applicable in Oregon**

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 may be guilty of insurance fraud.

**Applicable in 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 such person to criminal and civil penalties.

**Applicable in Maine/Tennessee/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.

**Applicable in all Other States**

Any person who knowingly 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Applicant understands and agrees that the completion of the application does not bind First Specialty Insurance Corporation to issuance of an insurance policy.

**THE APPLICATION MUST BE SIGNED AND DATED BY AN OWNER, OFFICER OR PARTNER.**

By checking this block I affirm that all changes and entries made to the application, unless otherwise noted, were approved by the undersigned on the date of signature below.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
(Please Print)

*The applicant understands and agrees that she or he is obligated to report any changes in the information provided in this application which occur after the date of the application.*