TRAVELERS

Insurance Professionals Liability Coverage
Life, Health and Accident Insurance Agents or Brokers
Professional Liability Insurance Claims-Made Application

St. Paul Fire and Marine Insurance Company

Claims-Made: The information requested in this Application is for a Claims-Made policy. If issued, the policy will apply only to claims first made during the policy period, or any applicable extended reporting period.

Defense Within Limits: The limits of liability will be reduced, and may be completely exhausted, by amounts paid as defense expenses, and any deductible will be applied against defense expenses. The Insurer will not be liable for the amount of any judgment, settlement, or defense expenses incurred after exhaustion of the limit of liability. (For policies issued in New York, the limit of liability may be reduced up to 50% for amounts paid as defense expenses, and the deductible may apply up to 50% of defense expenses.)

If the name differs from the full legal name of the Applicant, provide detail on a separate attachment.

GENERAL INFORMATION

Full Legal Name of Applicant:

Trade or Doing Business As Name:

Street Address:

City:		State:	Zip:
Primary Contact Name and Title:	Phone:	Fax:	Date Established:
Email Address:	Website Address:		

Ownership Type:					
☐ Individual	☐ Partnership	☐ Corporation	☐ LLC	☐ LLP	☐ Other:

DESCRIPTION OF OPERATIONS

1. Do you have any subsidiaries or branch offices? ☐ Yes ☐ No
   If Yes, provide the addresses of each office (Use a separate sheet if needed).

2. Are you or any member of your firm a member of NABIP? ☐ Yes ☐ No
   If Yes, provide member name:

3. Are you or any member of your firm a member of any other insurance professional organization? ☐ Yes ☐ No
   If Yes, describe:

4. During the past five (5) years, has the name of the agency, ownership or principals of the agency changed, or has any other business been purchased, merged or consolidated with the agency, including the purchase of another agency's business? ☐ Yes ☐ No
   If Yes, provide complete details including gross revenue derived from the other business, prior professional liability insurance and claims history.

5. During the past five (5) years, has any portion of your or business operations been sold or transferred to another person or business entity? ☐ Yes ☐ No
   If Yes, provide complete details including the date of sale or transfer, the amount and type of business or operations, and the person or entity that the business was sold or transferred to.

6. Is your firm, or any owner, partner or officer engaged in any other business operations or conduct business under any other name? ☐ Yes ☐ No

If Yes, provide complete details. _____

7. Are you or your agency owned by, affiliated or associated with or controlled by any other business, including any agency, brokerage or agency cluster type arrangement? ☐ Yes ☐ No

If Yes, provide details including name, percentage of ownership, description of business of parent or controlling interest, kind and amount of business derived from associated business or owner.

BUSINESS BREAKDOWN

8. Provide the gross annual commission and fee revenue from life and health products and services provided by your agency (revenue is based on commission income and fees before deduction of expenses). Include commission or revenue that is paid by your insurance carriers directly to your non-employee producers including sub-agents, brokers, and independent contractors for business that is placed through your agency. (Also include commission or fee revenue from mutual funds and/or property and casualty insurance if you are requesting this optional coverage.)

Revenue for the past 12 months: $ _____

Estimated revenue for next year: $ _____

9. Give the approximate percentage breakdown of the total business that is placed by you or your agency as a(n):

Agent (Personal Producing)	%	Brokerage General Agency	%
Broker (Personal Producing)	%	Managing General Agency	%
General Agent (P.P.G.A.)	%	Consultant (for fee)	%
Life Co. General Agent	%	Other (describe on separate sheet)	%

10. Break down your total revenues by percentage of professional activities during the past year. Total must equal 100% of total gross revenues in question 8 above. Provide a detailed explanation where required, attaching additional sheets if necessary.

a. Fully-insured life and annuity policies (individual and group) issued by licensed life companies: _____ %

b. Fully-insured health, A&H and medical policies (individual and group) issued by licensed life/A&H companies, regulated HMOs or service plans (Blue Cross/Shield): _____ %

c. Administration of fully-insured benefit plans or pension plans: _____ %

Describe: _____

d. COBRA administration or services: _____ %

e. Claims administration of fully-insured benefit plans: _____ %

Describe: _____

f. Property and casualty insurance (except California 24-hour worker's compensation): _____ %

If you desire coverage for property and casualty professional liability, you will need to complete the Property and Casualty Professional Liability Insurance Supplement.

g. California 24-hour type worker's compensation: _____ %

h. Mutual fund sales (exclusive of annuity/group or employee benefit plans): _____ %

i. Self-insured or self-funded employee benefits, pension, and/or medical plans: _____ %

Complete the Self-insured/Self-funded Business Supplement if you show any percentage here.

j. All other business activities: _____ %

Describe: _____

Business Activities must total 100% **TOTAL** **100%**

Optional coverage for Mutual Funds and Property and Casualty Insurance is available under this policy. See question 26.

11. Provide the full names of life/accident & health companies and % of total business with each:

1st		%	4th		%
2nd		%	5th		%
3rd		%	6th	(total of all other companies)	%

If more than 30%, provide name and rating of next 4 carriers.

PRODUCTION SOURCES

12. List all actively licensed persons who represent your agency. (All licensed persons including independent contractors must be named in order for coverage to apply to that individual.) **Include any sub-agents/independent contractors that you wish to include under your coverage for business that they place through your agency**. Attach a separate list if necessary.

		Licensed for: check all that apply and include the date first licensed				
*Licensed Persons	**Designation Code	LIFE	A&H	P&C	SEC (type/series #)	Professional Designations Held
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		

**Place an asterisk next to the name of any person licensed in Kentucky.*

***Designation Code: O = Owner, P = Partner, OF = Officer/Director, E = Employee, IC = Independent Contractor*

13. Indicate the number of unlicensed support staff employees: _____

14. Do you or your agency or any owner, partner or officer place business for, receive production from, or receive revenue based on the production of any non-employee producer, including sub-agents, independent contractors or other agents or brokers? ☐ Yes ☐ No

If Yes, complete the Sub-agent/Independent Contractor/Non-employee Producer Supplement

15. Indicate the percentage of your total business received:

Direct from your Insureds: _____ %

From other agents, brokers or non-employee producers who receive payment from you or from your carriers for this business: _____ %

16. List all states where licenses are held by you or anyone in your agency:

_____

_____

LOSS CONTROL QUESTIONS

17. Do you maintain a written office procedure manual? ☐ Yes ☐ No

If Yes, does it contain the following?

a. Procedures for handling all business transactions ☐ Yes ☐ No
b. File documentation requirements ☐ Yes ☐ No
c. Agency diary and recall procedures ☐ Yes ☐ No
d. Job descriptions/responsibilities for each employee ☐ Yes ☐ No
e. Guidelines for carrier ratings ☐ Yes ☐ No
f. Company Information ☐ Yes ☐ No

g. Agency statement regarding training and education ☐ Yes ☐ No

h. Role of the computer in the agency ☐ Yes ☐ No

18. Have you attended a Sponsored Loss Control Seminar in the past 12 months? (NABIP, NAIFA, PIA, IIA) ☐ Yes ☐ No

If Yes, specify who attended: # of principals: _____ # Staff/CSR: _____

CURRENT COVERAGE

19. Indicate your professional liability coverage for the past three (3) years and attach a copy of your last declarations page.
Check here if no insurance ☐

Carrier	Policy Expiration Date	Limits	Deductible	Annual Premium	Did coverage include all Products and Carriers?
		$	$	$	☐ Yes ☐ No
		$	$	$	☐ Yes ☐ No

20. If you have not carried professional liability coverage for the past three (3) years or have had a gap in coverage, explain why:

_____

_____

CLAIMS/LOSS HISTORY

21. Have you or any past or present owner, officer, employee or salespersons (whether employees or independent contractors) been the subject of any fines or disciplinary action by any insurance or other regulatory authority? ☐ Yes ☐ No

If Yes, attach an explanation.

22. Has any policy or application for professional liability insurance on behalf of the applicant or any of its past or present owners, officers, partners, employees or salespersons (whether employees or independent contractors), or to the knowledge of the applicant, on behalf of its predecessors in business, ever been declined, canceled or renewal refused within the past 10 years? *(Missouri applicants: Do not complete)* ☐ Yes ☐ No

If Yes, attach an explanation.

23. Have any professional liability claims been made against the applicant or any of its past or present owners, officers, partners, employees or salespersons (whether employees or independent contractors), or to the knowledge of the applicant, on behalf of any preceding business of yours, within the past five (5) years? ☐ Yes ☐ No

If Yes, complete a Supplemental Claim Form for each claim.

24. Are there any circumstances which may result in professional liability claims being made against the applicant, past or present owners, officers, partners, employees, or salespersons (whether employees or independent contractors) or its predecessor in business? ☐ Yes ☐ No

If Yes, complete a Supplemental Claim Form for each claim.

Note: Claims already made or potential claims that you are aware of prior to the policy inception are not covered.

COVERAGE DESIRED

25. Check the coverage limits and desired deductible:

Note: the $100,000/$300,000 limit option and $1,000 deductible is only available to firms with revenue less than $75,000. Availability of some Limit and Deductible options may be subject to underwriting and regulatory restrictions.

Coverage limits	Deductible
☐ $100,000/$300,000	☐ $1,000 (minimum)
☐ $250,000/$750,000	☐ $2,500
☐ $500,000/$1,500,000	☐ $5,000
☐ $1,000,000/$3,000,000	☐ $7,500
☐ Other: $ _____	☐ $10,000
	☐ Other: $ _____

26. Optional Coverage: The following professional coverage can be added to the policy for an additional premium charge. Indicate each coverage desired.

☐ Mutual Funds

☐ Property and Casualty

If you desire coverage for property and casualty professional liability, you will need to complete the Property and Casualty Professional Liability Insurance Supplement. Coverage is subject to underwriting consideration.

NOTICE REGARDING COMPENSATION

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Agency Compensation, One Tower Square, Hartford, CT 06183.

FRAUD STATEMENTS – ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company to defraud or attempt 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 to defraud or attempt to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds will be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND 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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company to defraud the company. Penalties include imprisonment, fines, and denial of insurance benefits.

OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

PUERTO RICO: Any person who knowingly and intending to defraud presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, will incur a felony and, upon conviction, will be sanctioned for each violation with the penalty of a fine of not less than $5,000 and not over $10,000, or a fixed term of imprisonment for three years, or both penalties. Should aggravating circumstances be present, the penalty established may be increased to a maximum of five years; if extenuating circumstances are present, it may be reduced to a minimum of two years.

SIGNATURES

The undersigned Authorized Representative represents that to the best of their knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and, except in North Carolina, may be relied upon by Travelers as the basis for providing insurance. The Applicant will notify Travelers of any material changes to the information provided.

☐ Electronic Signature and Acceptance – Authorized Representative*

*If electronically submitting this document, electronically sign this form by checking the Electronic Signature and Acceptance box above. By doing so, the Applicant agrees that use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes acceptance and agreement as if signed in writing and has the same force and effect as a signature affixed by hand.

Authorized Representative Signature: **X**	Authorized Representative Name and Title:	Date *(month/dd/yyyy)*:
Producer Name (required in FL & IA): **X**	State Producer License No (required in FL):	Date *(month/dd/yyyy)*:
Agency:		Agency Phone Number: