



Insurance Professionals Liability Coverage
Life, Health and Accident Insurance Agents or Brokers
Self-Insured/Self-Funded Business Supplement

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.)

Complete the following only if you receive revenue from your sales or activities involving self-insured or self-funded employee benefit plans, pension and/or medical plans.

GENERAL INFORMATION

Full Legal Name of Applicant:	Policy Number:
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DESCRIPTION OF OPERATIONS

1. Provide the number of years experience you have been providing this type of service/activity: _____

2. Provide the name(s) and current A.M. Best Company ratings for the insurer(s) or reinsurer(s) you use to place stop-loss coverage.

3. Provide the number of:
a. Accounts placed _____
b. Lives covered _____

4. Indicate the services you provide for each plan: _____

5. Do you have any TPA duties? Yes No
If Yes, provide complete details regarding your TPA activities: _____

6. Do you provide any underwriting, plan or claim administration? Yes No
If Yes, provide complete details regarding these activities: _____

7. Indicate who administers the plan(s): _____

8. Indicate who develops or designs the contract for the plan(s): _____

9. Provide complete details of how each plan is constructed, i.e., self-funded amount/stop loss protection:

10. Indicate if the stop loss coverage is:
 Fully funded 100% by insurance or reinsurance, or
 Partially funded by insurance or reinsurance with the plan purchaser(s) or participants responsible for a coinsurance portion or proportionate share of the stop loss coverage.
11. Do you provide any services for Multiple Employer Trusts or Multiple Employer Welfare Arrangements? Yes No
If Yes, provide complete details of these services: _____

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: