

NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS

Endorsed Program For: Professional Liability Insurance



STANDARD APPLICATION FORM

NOTICE: This Policy for which this application is being submitted is a claims made and reported policy, and subject to its terms and conditions, this Policy only covers claims first made against the Insured and reported to the Insurer in writing during the policy period.

Please submit application by mail to: NAIFA PROGRAM, P.O. Box 7048, Orange, CA 92863-7048; or

Fax: (866)-893-1198

Phone: (888) 833-2304 • www.naifaeo.com

Insurer: Aspen American Insurance Company, 175 Capital Blvd., Rocky Hill, CT 06067; Phone Toll Free: (877) 245-3510



Answer All Questions.

If the answer is none, state "none". If an explanation is requested or space provided is insufficient, please attach a separate sheet to explain. Application must be completed in ink, signed and dated by the named applicant.

YOUR INFORMATION (PLEASE PRINT CLEARLY)

Name _____ Agency Name _____

Street Address _____

City _____ State _____ Zip _____

Email: _____

Daytime Phone _____ Fax _____

NAIFA Membership Number _____ Name of your NAIFA Chapter _____
(Required to bind coverage.)

Have you taken a NAIFA approved Risk Management course in the last three (3) years? Yes No

Please attach your Certificate of Completion.

Is your business operating as a corporation? Yes No Desired Effective Date _____

How did you hear about the program? NAIFA Member Referral CalSurance Referral Ad in Advisor Today
 Web Search NAIFA Website Flyer Other

ELIGIBILITY INFORMATION

1. Do you produce **less** than 50% of your revenue from life, annuities, accident and health insurance products? Yes No
2. Do you operate as an independent marketing organization, Field Marketing Organization, Brokering General Agent or similar marketing entity? Yes No
3. Do you or does anyone in your agency have the authority to perform activities which would customarily be performed by an insurance company, such as underwriting or claims administration? Yes No
4. Do you or anyone in your agency have ownership interest in a broker/dealer organization? Yes No
5. Are you, the agency or anyone in the agency operating under any chapter of Federal bankruptcy Laws? Yes No
6. Have you or any past or present owner, officer, partner, employee or solicitor been the subject of disciplinary action by any insurance or other regulatory authority? Yes No

If you answered "YES" to questions 1 – 6 above, you are **NOT** eligible for this program.

7. Are you or is anyone in your agency an employee of a/an insurance company, automobile dealership or FINRA broker dealer? Yes No
8. In the last five years have you or your agency had any contracts cancelled for reasons other than lack of production? If "YES" attach an explanation. (Not applicable in Missouri) Yes No
9. Do you operate as a General Agent, Managing General Agent or similar entity? Yes No

INDIVIDUAL APPLICANT PROCEED TO PAGE 2. AGENCY APPLICANT PROCEED TO PAGE 4.

INDIVIDUAL AGENT APPLICATION

Complete this section only if you are applying as an Individual Agent.
Agency Applicants skip to Page 3

Individual Agent Coverage: You are the "named insured" and coverage includes your non-producing clerical staff.
 (If your gross commission income is in excess of \$500,000 you **must** apply as an agency.)

1. Have you been established for 3 or more years? Yes No
2. Date of Inception? _____ (Month/Day/Year)
3. Your current annual revenue last 12 months \$ _____
 (If new, estimated revenue for this year)
4. Number of Staff _____
5. List all States where you are licensed to do business:

6. List the top three (3) companies in which you place business (by revenue).

PROFESSIONAL SERVICES AND REVENUE

Identify percentages of total revenue that was earned last year from all professional activities:

a. Life _____ %	h. Products in a structured settlement arrangements _____ %	n. Insurance Consulting _____ %
b. Corporate Owned Life Insurance Products (COLI) _____ %	i. Mutual Funds _____ %	o. Tax Consulting _____ %
c. Health _____ %	j. Other Financial Products (Do not include variable products or mutual funds) _____ %	p. Estate Planning _____ %
d. Multiple Employer Trusts/Multiple Employee Welfare Arrangements _____ %	k. Property/Casualty Products _____ %	q. RIA/Financial Planning on a Fee basis _____ %
e. Long Term Care _____ %	l. Benefit/Pension Consulting _____ %	r. Sale of Viatical Investments _____ %
f. Self Insured Health Products _____ %	m. Pension, Claims or Third Party Administration _____ %	s. Sale of Life Settlements _____ %
g. Annuities _____ %		t. Other (Specify) _____ %
		Total (Items a through t) _____ %
		Must Total 100%

COVERAGE DESIRED

COVERAGE LIMITS (Check One)

- \$100,000 / \$300,000
- \$250,000 / \$500,000
- \$500,000 / \$1,000,000
- \$1,000,000 / \$2,000,000
- \$2,000,000 / \$2,000,000

**The highest limit available in Alabama, Louisiana and Texas is \$1,000,000/\$2,000,000.*

DEDUCTIBLE (Check One)

- \$1,000
- \$2,500

COVERAGE ENHANCEMENTS – SELECT ENDORSEMENTS REQUIRED

- Mutual Funds Only*
- Financial Products (Stocks, Bonds, Unit Investment Trusts, Limited Partnerships and Mutual Funds)*
- P&C Coverage (**Complete Supplemental Page 6**)

*Coverage will be sublimited to policy limit, but never greater than \$2 million per claim/aggregate.

(Please go to page 7 to complete your application.)

AGENCY APPLICATION

(Individual Agent Applicants may skip Page 3-6)

Your Agency is the "Named Insured" and coverage includes owners, officers and employees of the Named Insured. Non-employee agents are not covered unless approved and added to the policy by endorsement.

1. Has your agency been established for three (3) or more years? Yes No
If Agency has not been established for three (3) years all agents must apply as individuals. Please fill out the Individual Agent Application for each agent – Page 2.

2. Date Agency established? _____ (Month/Year)

3. Within the past five (5) years, has there been a change in name, ownership, merger with/or a purchase of another agency? Yes No

4. Does the agency have additional business locations or is the agency doing business under a name other than listed on this application? **If YES**, please attach full details. Yes No

5. List all states where licenses are held by your or anyone in your agency.

6. Please indicate the number of personnel in your agency. Designate each person under one category only.

Owners, Officers, Partners

Employee Producers, Brokers, Agents

Other Employees (including clerical)

Total Staff (Including clerical)

Total Number of Sub-Agents / Non-Employee Producers

7. Please provide information for you or for members of your agency including all owners, officers, licensed employee producers. (Please use the enclosed "Breakdown of Agency Staff" Supplemental Form.)

NON-EXCLUSIVE AGENTS

1. Is coverage desired for non-exclusive agents producers of the applicant for business placed only through the applicant? Yes No
 If YES, list non-exclusive agents who are to be covered for acts in the sale and servicing of business written through your agency. Also indicate their Errors & Omissions coverage for the past three (3) years and attach a separate sheet if needed. Please note that coverage for the Named Insured and/or any Non-Exclusive Agent extends solely to those Non-Exclusive Agents that are disclosed to the Underwriter and listed on any Policy issued. If the Named Insured contracts with any new Non-Exclusive Agents during the Policy Period and after issuance of the Policy, the Named Insured must submit these new Agents for further underwriting and potential addition to the Policy.

Name	Annual Commission from Non-Exclusive Agent	Name of Carrier	Policy Period	Policy Number (if available)

2. Do you require evidence that all your non-exclusive agents carry Errors & Omissions coverage each year? Yes No

PROFESSIONAL SERVICES AND REVENUE

Please provide the following information for you or your agency based on the previous year's activities and revenue. ***If you have been licensed for less than 3 years, please estimate activities and revenue for the next year and use the projected total revenue when providing the following information.***

1. Provide the gross annual income (commission and fee revenue) from your life and health agency/operation:

	Gross Agency Commissions*	Fee (Provide explanation of fees, if any)	Total Revenue
Last 12 months			
Estimated (next 12 months)			

*Includes commission earned through non-exclusive agents.

2. Identify percentages of total revenue that was received last year as:
- | | |
|-------------------------------------|---------|
| a. Agent | _____ % |
| b. General Agent | _____ % |
| c. Managing or Master General Agent | _____ % |
| d. Brokerage General Agent | _____ % |
| e. Other (Explain) | _____ % |
-
3. Identify by percentage your sources of total revenue:
- | | |
|-------------------------|---------|
| a. Personal production | _____ % |
| b. From your sub-agents | _____ % |
| c. From other agents | _____ % |
- TOTAL 100%**

TOTAL 100%

4. Identify percentages of total revenue that was earned last year from all professional activities:
- | | | | | | |
|--|---------|--|---------|--|---------|
| a. Life | _____ % | h. Products in a structured settlement arrangements | _____ % | n. Insurance Consulting | _____ % |
| b. Corporate Owned Life Insurance Products (COLI) | _____ % | i. Mutual Funds | _____ % | o. Tax Consulting | _____ % |
| c. Health | _____ % | j. Other Financial Products (Do not include variable products or mutual funds) | _____ % | p. Estate Planning | _____ % |
| d. Multiple Employer Trusts/Multiple Employee Welfare Arrangements | _____ % | k. Property/Casualty Products | _____ % | q. RIA/Financial Planning on a Fee basis | _____ % |
| e. Long Term Care | _____ % | l. Benefit/Pension Consulting | _____ % | r. Sale of Viatical Investments | _____ % |
| f. Self Insured Health Products | _____ % | m. Pension, Claims or Third Party Administration | _____ % | s. Sale of Life Settlements | _____ % |
| g. Annuities | _____ % | | | t. Other (Specify) | _____ % |
| | | | | Total (Items a through t) | _____ % |

5. Do you or does anyone in your agency have the authority to perform activities which would customarily be performed by an insurance company, such as underwriting or claims administration? Yes No

6. Regarding your office procedures, please answer the following questions:
- | | |
|---|--|
| a. Is there a procedure for documenting client and carrier telephone conversations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Are all applications, policies and riders checked for accuracy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Do you or does your agency have a system for client / carrier follow-up? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

7. List the top five companies with which you place business (based upon total revenue):

NAME OF COMPANY	TYPE OF POLICY	ANNUAL COMMISSION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

COVERAGE DESIRED

Please check the coverage limits and desired deductible:

- | | | |
|--|---|--------------------------|
| Coverage Limits* | Deductible | Requested Effective Date |
| <input type="checkbox"/> \$500,000/\$1,000,000 | <input type="checkbox"/> \$1,000 | _____ / _____ / _____ |
| <input type="checkbox"/> \$1,000,000/\$2,000,000 | <input type="checkbox"/> \$2,500 | |
| <input type="checkbox"/> \$2,000,000/\$2,000,000 | <input type="checkbox"/> \$5,000 | |
| <input type="checkbox"/> \$3,000,000/\$3,000,000** | <input type="checkbox"/> \$7,500 | |
| <input type="checkbox"/> \$4,000,000/\$4,000,000** | <input type="checkbox"/> \$10,000 | |
| <input type="checkbox"/> \$5,000,000/\$5,000,000** | <input type="checkbox"/> \$ _____ (Up to \$25,000 - AGENCIES only.) | |

Note: Limits and deductible selected are subject to underwriting approval.
 * The highest limit available in the states of Alabama, Louisiana and Texas is \$1,000,000/\$2,000,000.
 ** These higher limits are available for agency coverage only.

Please see the "Supplemental Coverage Application" for Mutual Funds, Financial Products or Property Casualty coverage options.



BREAKDOWN OF AGENCY STAFF

Principals, Owners, Officers and Managers:

Name	Title	Producing Yes/No	Years of Insurance Experience	Licenses Held & Year License Obtained (CHECK ALL THAT APPLY AND INCLUDE YEAR LICENSED FOR EACH)			
				<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
				<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
				<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
				<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
				<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
				<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____

Licensed Producers*:

Name	Title	Years of Insurance Experience	Licenses Held & Year License Obtained (CHECK ALL THAT APPLY AND INCLUDE YEAR LICENSED FOR EACH)			
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____
			<input type="checkbox"/> P&C: _____	<input type="checkbox"/> Life: _____	<input type="checkbox"/> Series VI: _____	<input type="checkbox"/> Series VII: _____

*Sub-Agents to be listed on page 3 or additional sheet.

ATTACH ADDITIONAL SHEETS AS NEEDED

SUPPLEMENTAL COVERAGE APPLICATION

List Agent and Affiliated Broker Dealer for each agent requiring coverage:

I. MUTUAL FUNDS (AGENCY APPLICANTS ONLY)

Coverage will be sublimited to policy limit, but never greater than \$2,000,000 per claim/aggregate.

Name	Broker Dealer

II. FINANCIAL PRODUCTS (AGENCY APPLICANTS ONLY)

Coverage will be sublimited to policy limit, but never greater than \$2,000,000 per claim/aggregate.

Name	Broker Dealer

III. PROPERTY & CASUALTY

Total P&C Revenue/Commission	\$
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Please indicate the percentage of commission or fees derived from each line of business listed below.

Personal Lines	%	Construction/General Contracting	%	Other Lines:	%
Commercial Lines		Long Haul Trucking		(List Other Lines)	
Business Owners Policies		Workers Compensation			
Property		Livestock			
General Liability		Crop			
Commercial Auto		Medical Malpractice			
Trucking		Professional Liability			
Commercial Auto		Inland Marine			
		Wet Marine			
		Aviation			
		Bonds			

List of top three (3) P&C insurance carriers business is placed with and the revenues (commission) derived from placement.

Insurance Carrier	Revenue

CURRENT COVERAGE AND CLAIMS/LOSS HISTORY

1. Indicate your Errors & Omissions coverage for the past three years and attach a copy of your last Declarations Page. If you are applying for agency coverage, indicate Your Agency's Errors and Omissions coverage for the past three years and attach a copy of your last Declarations Page. If no agency coverage previously existed, please list the Errors and Omissions coverage for each agent under their individual Errors and Omissions policies. If none, state "none".

Name of Carrier	Limits	Policy Term		Did Coverage include all Products & Carriers?
		Effective Date	Expiration Date	
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Have you or any past or present owner, officer, partner, employee or solicitor been the subject of disciplinary action by an insurance or other regulatory authority? If Yes, attach an explanation. Yes No
- (Question 3 is not applicable to Missouri applicants)** Yes No
3. 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, 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 past 7 years? If Yes, attach an explanation.
4. Have any Errors and Omissions claims been made against the applicant or any of its past or present owners, officers, partners, employees or solicitors, or to the knowledge of the applicant, on behalf of its predecessors in business, within the past 7 years? (If Yes, please use the "Claim Information – Supplemental" form to provide details for each claim) Yes No
5. Are there any circumstances which may reasonably be expected to give rise to an Errors and Omissions claims being made against the applicant, past or present owners, officers, partners, employees or solicitors, or its predecessor in business? If **YES**, attach an explanation. Yes No

WARRANTY: PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES/SITUATIONS

1. The Applicant must complete the Warranty Statement below:
 - For any coverage which is requested and not currently purchased from Aspen, as indicated in this Application; or
 - If the Applicant is requesting larger limits than are currently purchased from Aspen, as indicated in this Application.

For Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Kansas, Kentucky, Maine, Massachusetts, Missouri, Montana, Nebraska, New Hampshire, Nevada, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Virginia, Washington, West Virginia and Wyoming Residents ONLY: the title of this section and any other reference to "Warranty" is deleted and replaced with "Representation".

Warranty Statement: No person or entity to be covered under the proposed coverage is aware of any fact, circumstance, or situation which he or she could reasonably expect to give rise to any claim that would fall within the scope of the proposed coverage:

NONE, OR EXCEPT as outlined below:

NOTICE: Without prejudice to any other rights and remedies of Aspen, the Applicant understands and agrees that if any such fact, circumstance or situation exists, whether or not disclosed above in response to Question 1 above, any claim arising from such fact, circumstance, or situation is excluded under the proposed policy if issued by Aspen.

AUTHORIZATION AND DECLARATION

Applicant hereby represents that the statements and answers to questions made above and attachments hereto are true and applicant has not omitted or misrepresented any information. Applicant understands and agrees that the completion of this application does not bind the insurance carrier to issue an insurance policy. Applicants domiciled in New Mexico, Oregon and Wisconsin further agree that this application shall be the basis of the contract should a policy be issued and it will be deemed attached to and a part of the policy. Further, the applicant understands and agrees that she or he is obligated to report any changes in the information provided in this application that occur after the date of the application. Applicant understands that this policy can be issued only to agents/agencies that meet NAIFA membership requirements. Applicant understands and agrees that, if not currently qualified for coverage due to the lack of local life underwriter association membership, you and/or the necessary producers must so join before any policy is issued. In such cases, forms will accompany the offer of coverage on which the applicant will be required to verify local life underwriter association membership and return the proof with acceptance of the offer.

This Policy is underwritten by Aspen American Insurance Company.

NOTICE TO NEW YORK APPLICANTS: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signature: _____
(Must be signed by Owner, Partners or Senior Officer)

Date: _____
(Month/Day/Year)

Title: _____

- | | | |
|---|------------------------------|-----------------------------|
| 1. Is every question answered? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you attached copies of your errors and omission certificates? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you provided an explanation of the questions where required? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you signed and dated the application? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

This section to be completed by the Producer for accounts domiciled in Florida and Iowa.

Producer Signature

Producer Name

Producer License Number

Date

Please submit application by mail to: P.O. Box 7048, Orange, CA 92863-7048; or
Fax: (866) 893-1198
Phone: (888) 833-2304 • www.naifaeo.com

FRAUD WARNINGS

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND NEW MEXICO APPLICANTS: 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.

NOTICE TO COLORADO APPLICANTS: 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 AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: 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.

NOTICE TO FLORIDA APPLICANTS: 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 IN THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: 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.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

CLAIM INFORMATION - SUPPLEMENTAL

(To be completed if you have had prior claims. One form should be completed for each claim.)

1. Name of Applicant: _____
2. Name of Person Involved in Claim: _____
3. Name of Claimant: _____
4. Date of Error: _____
5. Date of Claim: _____
6. Name(s) of Additional Defendant(s): _____
7. Name of E&O Carrier: _____
8. Claim Status: Open In Suit Closed
9. If Paid:
 - a. Amount of Damages Paid: _____
 - b. Amount of Expenses Paid: _____
10. If Open or in Suit:
 - a. Claimant's Settlement Demand: _____
 - b. Defendant's Offer for Settlement: _____
 - c. E&O Carrier Loss Reserve: _____
11. Act, error or omission alleged by claimant:

12. Description of claim and events:

13. What steps have been taken to reduce the likelihood of a reoccurrence of this type of claim?

MUST BE SIGNED AND DATED BY OWNER, PARTNER OR SENIOR PARTNER.

Name: _____
(Print Name)

Title: _____
(Print Title)

Signature: _____
(Must be signed by Owner, Partners or Senior Officer)

Date: _____
(Month/Day/Year)