

**THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. EXCEPT AS OTHERWISE PROVIDED, THE POLICY WILL COVER ONLY CLAIMS FIRST MADE AGAINST THE APPLICANT AND REPORTED TO THE INSURER DURING THE POLICY PERIOD.**

**PLEASE NOTE THAT THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES SHALL BE REDUCED AND MAY BE COMPLETELY EXHAUSTED BY PAYMENT OF CLAIMS EXPENSES. DAMAGES AND CLAIMS EXPENSES SHALL BE APPLIED AGAINST THE DEDUCTIBLE.**

**Notes to Applicant:**

- Complete all questions in full in **BLOCK CAPITALS** or type
- If space is insufficient to answer any questions, please complete them on an additional sheet
- Application must be signed and dated by a principal of the Applicant

1. Name of Applicant: \_\_\_\_\_

DBA (if applicable): \_\_\_\_\_

2. Address of Applicant: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Additional locations (if applicable): \_\_\_\_\_

3. Date Firm established or Independent Contractor first licensed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**If within the last three (3) years, please attach license(s) and resume(s) for all principals**

4. Please indicate type of company:

Corporation  Partnership  Sole Proprietorship

Other: \_\_\_\_\_

5. In the past five (5) years;

a. Has the Applicant's firm name ever changed or has there been any acquisition, consolidation, dissolution, merger or change in business organization? Yes  No

If "Yes", please explain: \_\_\_\_\_

b. Has there been any change in management structure, including any additions or deletions of principals, owners, managers or brokers? Yes  No

If "Yes", please explain: \_\_\_\_\_

6. Is the Applicant employed by, affiliated with, or in any way associated with any other insurance agency or broker? Yes  No

If "Yes", please provide full name and address: \_\_\_\_\_

\_\_\_\_\_

7. Please indicate the number of:

a. Owners, Officers, Partners: \_\_\_\_\_

b. Non-exclusive Non-employee Producers: \_\_\_\_\_

c. Employed Agents, Brokers, Solicitors: \_\_\_\_\_

d. Exclusive Non-Employee Producers: \_\_\_\_\_

e. All other employees: \_\_\_\_\_

f. Total number full-time employees: \_\_\_\_\_

g. Total number of part-time employees: \_\_\_\_\_

h. Number of employees with professional designations: \_\_\_\_\_

i. Number of licensed agents, brokers, solicitors, partners, officers: \_\_\_\_\_

8. Does the Applicant have a website? Yes  No

If "Yes", is it used for:

i. Marketing? Yes  No

ii. Placing business? Yes  No

iii. Accepting submissions? Yes  No

Please provide website address: \_\_\_\_\_

9. Please provide:	Past 12 months	Estimated next 12 months
a. Total premium volume:	US\$ _____	US\$ _____
b. Total commission volume:	US\$ _____	US\$ _____
c. Total income from other activities:	US\$ _____	US\$ _____

10. Percentage of business placed with carriers: Admitted: \_\_\_\_\_% Non-admitted \_\_\_\_\_%

11. Percentage of business placed with carriers: Direct: \_\_\_\_\_% Broker \_\_\_\_\_%

12. List top three carriers for the last twelve (12) months:

Insurance Company	Volume of Premium Placed	Admitted?	AM Best Rating
a. _____	US\$ _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
b. _____	US\$ _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
c. _____	US\$ _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

13. Please indicate percentage of business placed by Premium volume for the past twelve 12 months:  
**(Total of all lines to add up to 100%)**

PERSONAL LINES		COMMERCIAL LINES	
Auto (Standard)		Auto (Other than Long Haul Trucking)	
Auto (Non-Standard) / Motorcycles		Aviation	
Homeowners		Business Owner's Policy	
Non-standard Fire		Crop Insurance	
Personal Marine		Fire & E.C.	
Wind/Flood/Earthquake		General Liability (non-BOP)	
Umbrella		Jeweler's Block	
Other (Please specify):		Livestock Mortality / Bloodstock	
<b>Total Personal Lines:</b>		Long Haul Trucking	
		Marine - Inland	
<b>LIFE &amp; ACCIDENT AND HEALTH</b>		Medical Malpractice	
Individual Accident & Health		Marine - Ocean	
Individual Life		Package Policies	
Group Accident & Health		Pollution Liability	
Group Life		Professional Liability, D&O, E&O	
Other (Please specify):		Reinsurance	
<b>Total Life and A&amp;H:</b>		Worker's Compensation	
		Other (Please specify):	
		<b>Total Commercial Lines:</b>	

14. List all companies currently rated "NR" or "B+" or less by A.M Best with whom the Applicant placed business in the last three (3) years (if none, write "NONE"):

Insurance company	Premium placed	Current A.M. Best Rating
_____	US\$ _____	_____
_____	US\$ _____	_____
_____	US\$ _____	_____

15. In the last twelve (12) months, what percentage of business did the Applicant place as an:

- a. Agent \_\_\_\_\_%
- b. Broker/wholesaler \_\_\_\_\_%
- c. Managing General Agent \_\_\_\_\_%
- d. Reinsurance Intermediary \_\_\_\_\_%
- e. Surplus Lines Agent \_\_\_\_\_%
- f. Third Party Administrator \_\_\_\_\_%

16. Is the Applicant involved in the following activities? If yes, please indicate the percentage of total revenue received from each one:

- |                                |                              |                             |         |
|--------------------------------|------------------------------|-----------------------------|---------|
| a. Claims Adjusting            | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ % |
| b. Law Practice                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ % |
| c. Loss Prevention Engineering | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ % |
| d. Mutual Funds                | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ % |
| e. Premium Financing           | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ % |
| f. Real Estate                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ % |

**PLEASE NOTE: No coverage is given for any of the above activities unless specifically agreed by endorsement to the policy.**

17. Is the Applicant involved in any other activities not already listed in questions 15 and 16?

Yes  No

If "Yes", please list additional activities: \_\_\_\_\_

18. Please indicate if the Applicant:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a. Delegates binding authority to sub-producers | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Adjusts claims                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Has authority to deny claims                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Negotiates / Purchases Reinsurance           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

19. Does the Applicant:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Use In-House Procedure Manuals?                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. Document all business related telephone conversations?          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. Date stamp incoming mail?                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. Check all applications, policies and endorsements for accuracy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. Maintain a diary/suspense system?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Send copies of binders to their insured promptly?               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. Maintain a policy expiration list?                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. Utilize a computerized production and accounting system?        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If the Applicant answered "Yes" to any of the above, please describe the procedures used to ensure that they are implemented accurately (i.e. regular internal audit):

---

---

---

20. Do you have a specific orientation program / office manual review for all new employees? Yes  No
21. Have any employees attended any E&O loss prevention seminars or other industry related education courses within the past two (2) years? Yes  No
22. Does the Applicant confirm all declinations of coverage in writing? Yes  No
23. Are customers advised in writing whenever insurance coverage cannot be bound immediately or when special restrictions and/or endorsements apply? Yes  No
24. Does the Applicant obtain instructions in writing from customers who want their insurance coverage amended? Yes  No
25. In what percentage of cases does the Applicant agree a written contract with a customer? \_\_\_\_\_ %  
Where a written contract is not used, please explain how the scope of services to be provided is agreed:  
\_\_\_\_\_  
\_\_\_\_\_
26. Is any errors and omissions or professional liability insurance in favour of the Applicant currently in force? Yes  No

If yes, please indicate:

a. The insurance carried for each of the past five (5) years:

Carrier	From (mm/yy)	To (mm/yy)	Limit / Agg. Limit	Deductible	Premium
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

b. The current retroactive date: \_\_\_\_\_

27. Please indicate the insurance that the Applicant is requesting:

a. Per Claim Limit: US\$ \_\_\_\_\_

b. Aggregate Limit: US\$ \_\_\_\_\_

c. Deductible: US\$ \_\_\_\_\_

28. During the past five years has any insurance company declined, cancelled or refused to renew cover for the Applicant? Yes  No

If "Yes", please provide details: \_\_\_\_\_  
\_\_\_\_\_

29. Is the Applicant aware of any errors, omissions or claims (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years? Yes  No

If "Yes", please complete the claims information supplement (Attachment 'A')

**IF ANY SUCH CLAIMS EXIST, OR ANY SUCH FACTS OR CIRCUMSTANCES EXIST WHICH COULD GIVE RISE TO A CLAIM, THEN THOSE CLAIMS AND ANY OTHER CLAIMS ARISING FROM SUCH FACTS OR CIRCUMSTANCES WILL BE EXCLUDED FROM THE PROPOSED INSURANCE.**

30. Has the Applicant been a party to any lawsuit or other legal proceeding within the past five years? Yes  No

If yes, please provide (on Attachment 'B') a description which includes the venue of the action, the parties, the amount at dispute, the nature of the claim(s), the status of the action(s) and how the action(s) was resolved as to the applicant, including all costs incurred and defense expenses.

31. Is the Applicant aware or does the Applicant have any knowledge or information of any act, error, omission, fact or circumstance which may give rise to a claim which may fall within the scope of the proposed insurance? Yes  No

**IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM WILL BE EXCLUDED FROM THIS PROPOSED INSURANCE.**

**NOTICE: IN SOME STATES, 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. IN NEW YORK, A PERSON WHO COMMITS SUCH CRIME SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.**

**This Application must be signed and dated by a Principal of the Applicant:**

I/We hereby declare that the above statements and declarations are true and that I/we have not suppressed or misstated any material facts. I/We agree that any misrepresentation or misstatement of material facts may void coverage under the proposed Insurance. I/We agree that this application shall be the basis of the Contract with the Insurer and that coverage, if written, will be provided on a claims made basis. It is understood and agreed that completion of this application neither binds the Insurer to provide coverage nor the Applicant to purchase the insurance.

I/We agree that if the information supplied on this application changes between the date the application is executed and the time the proposed insurance policy is bound or coverage commences, the Applicant will immediately notify Catlin in writing of such changes. Catlin reserves its rights to modify or withdraw its proposal following such changes.

Applicants Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**ATTACHMENT 'A'  
SUPPLEMENTAL CLAIMS INFORMATION**

1. Applicant's Name: \_\_\_\_\_
2. Full name of individual involved in the claim: \_\_\_\_\_
3. Full name of Claimant: \_\_\_\_\_
4. Date of Alleged Error: \_\_\_\_\_
5. Date of Claim: \_\_\_\_\_
6. Additional Defendants: \_\_\_\_\_
7. Name of Insurer advised of the claim: \_\_\_\_\_
8. Present Status of Claim:      Open       Closed       In Suit
9. If Closed:
  - a. Total Loss paid      \_\_\_\_\_
  - b. Expense paid      \_\_\_\_\_
10. If Open:
  - a. Amount asked in Summons      \_\_\_\_\_
  - b. Claimants Settlement demand      \_\_\_\_\_
11. Defendant's offer for settlement      \_\_\_\_\_
12. Insurer's Loss Reserve      \_\_\_\_\_
13. \* Description of Claim – if Open, include assessment of liability:
  - a. \* Description of Claim and events: \_\_\_\_\_  
\_\_\_\_\_
  - b. \* Allegations claim based on: \_\_\_\_\_  
\_\_\_\_\_
13. \* Explain what action(s) have been taken to prevent a recurrence or similar claim:  
\_\_\_\_\_  
\_\_\_\_\_

This Attachment must be signed and dated by a Principal of the Applicant:

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

Title: \_\_\_\_\_

\* Use additional paper as required



**ATTACHMENT 'B'  
SUPPLEMENTAL INFORMATION**

This Attachment must be signed and dated by a Principal of the Applicant:

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

Title: \_\_\_\_\_