

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED INSURANCE POLICY. IT IS IMPORTANT THAT YOU REPORT ANY KNOWN FACTS OR CIRCUMSTANCES THAT COULD REASONABLY BE EXPECTED TO RESULT IN A CLAIM TO YOUR CURRENT INSURER OR PURCHASE AN EXTENDED REPORTING PERIOD ENDORSEMENT IN ORDER TO PRESERVE COVERAGE FOR SUCH INCIDENTS.

Firm:					
Contact:				Date Firm Established:	
Address :					
Phone:		Fax:		Email:	
Fed ID:		No. Lawyers in Firm:		No. Support Staff:	
Do you have other office locations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? Please provide a list showing each location and the number of attorneys at each location					
1.	Has any professional liability insurance for the applicant, or any member of the applicant firm ever been declined or canceled, refused to be renewed or accepted only on special terms?				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	a. Is any member of the firm an employee, officer, director, shareholder, member, of or exercise fiduciary control over an entity other than the applicant firm?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Does any firm member have an equity interest in an outside entity?				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has any member of the firm provided legal services involving publicly traded securities or securities that are not exempt from registration?				<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any member of the firm been involved in class action or mass tort litigation?				<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Does any firm member provide services to, or sit on the board of directors of, a financial institution?				<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	a. Is any member of the firm aware of any incident, facts, circumstances, acts or omissions that could result in a professional liability claim against the firm or predecessor firm?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If yes, has a complete Supplemental Claim form been provided for each incident?				<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Has any member of the firm been the subject of any reprimand or disciplinary action or refused admission to the bar or any bar association, court or administrative agency?				<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	a. In the last five (5) years, has any professional liability claim been made or suit brought against any member of the firm or predecessor firm? If yes, how many?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If yes, has a complete Supplemental Claim form been provided for each incident?				<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Does your firm have a system for detecting and avoiding conflicts of interest?				<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	How many suits for fees have been filed against clients in the last two years?				
11.	a. Does the firm maintain a docket control system with at least two independent date controls?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If yes, is the docket control system maintained by two individuals?				<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Does the firm routinely use engagement and non-engagement letters?				<input type="checkbox"/> Yes <input type="checkbox"/> No

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 MATERIAL FACT THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SUBJECTS THE PERSON TO CRIMINAL AND (NY: SUBSTANTIAL) CIVIL PENALTIES. (NOT APPLICABLE IN CO, FL, HI, MA, NE, OH, OK, OR, OR VT; IN DC, LA, ME, TN, VA AND WA, INSURANCE BENEFITS MAY ALSO BE DENIED.)

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 IN THE THIRD DEGREE.

APPLICANT’S AUTHORIZATION AND CERTIFICATION

The undersigned is an authorized representative of the prospective Named Insured, and acknowledges that the information provided with the application, including all supplements, attachments and replies to underwriter inquiries, and applications from other insurance companies which have been submitted to the Company and made a part of this application:

- 1. Will be relied upon by the Company in determining the acceptability of the Applicant and the premium amount to be charged;
- 2. Are true, accurate and complete; and
- 3. Will be incorporated into the policy, if issued.

The applicant firm and all members of the firm understand that this is an application for insurance, and shall not bind the Company to the issuance of insurance, nor shall it bind the firm to the acceptance of a policy.

THE UNDERSIGNED ON BEHALFOF THE APPLICANT FIRM AND ALL MEMBERS OF THE FIRM CERTIFIES THAT THE ABOVE APPLICATION HAS BEEN READ AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. THE UNDERSIGNED UNDERSTANDS THAT: (1) IF THE POLICY IS ISSUED, THIS IS DONE BY THE COMPANY IN RELIANCE UPON THESE REPRESENTATIONS; AND (2) ANY COVERAGE OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION IS VOID.

Signature of Firm Principal			Print Name and Title		Date
Agency:				Phone:	
Address:				Fax:	