

COVER-PROSM APPLICATION - MO

NOTICE: This professional liability coverage is provided on a claims-made basis; therefore, claims which are first made against you, and reported to the Company, during the policy period are eligible for coverage, subject to policy provisions.

1. Name of the Applicant Firm:

2. Applicant principal location:
 Street Address:
 City: State: Zip Code:
 Website: E-mail address:

3. Risk Management Contact: Risk Management's Phone:
 Risk Managements Email:

4. Date established: Telephone:

5. Describe the Applicant's nature of business:

6. Is the Applicant Firm controlled, owned, affiliated or associated with any other firm, corporation or company? Yes No
If yes, please provide an explanation.

7. Please list the address(es) of all branch offices and/or subsidiaries. **Include a brief description of their operations and indicate if coverage is desired for these offices.**
Branch Office(s):

Subsidiary(ies): (Please note that our policy does not provide automatic coverage for subsidiaries)

8. During the past five (5) years has the name of the firm been changed or has any other business(es) been acquired, merged into or consolidated with the Applicant firm? Yes No
If yes, provide a complete explanation detailing any liabilities assumed.

9. Staffing- Provide a breakdown of the Applicant's staff into the following categories:
 - a. Principals, Partners or Officers:
 - b. Professionals (not included in A):
 - c. Support staff (including part-time):
 - d. Part-time professionals (less than 20 hr/wk):**TOTAL:**

10. Are any staff members considered "Licensed Professionals" or do any staff members hold any professional designations or belong to any professional societies/ associations? Yes No
If yes, provide the individual's name and designation/affiliation:

11. Dates of the Applicant's current fiscal period: From: To:

	PAST FISCAL YEAR	CURRENT FISCAL YEAR	ESTIMATE – NEXT YEAR
Total Gross Annual Revenue	\$	\$	\$

12. Provide the percentage of the Applicant's gross annual revenue from the last fiscal period attributable to the following:
- | | |
|---|---|
| Federal government: | % |
| State, county or local government and agency thereof: | % |
| Institutional (schools, hospitals, etc...): | % |
| Lending institutions: | % |
| Manufacturing: | % |
| Other (specify): | % |

13. Does the Applicant provide services for any clients in which a principal, partner, officer or employee of your firm is also a principal, partner, officer, employee or a more than three (3)% shareholder of said client? Yes No
If yes, please provide the following:
- a. Client name:
 - b. Applicant's relationship with the client:
 - c. Approximate annual gross revenue generated from this client: \$

14. Were more than fifty (50)% of the Applicant's total gross annual billings for any one year derived from a single client or contract? Yes No
If yes, provide the following:
- a. Client name:
 - b. Services rendered:
 - c. How long do you expect this relationship to continue?

15. Describe the Applicant's three (3) largest jobs or projects during the past three (3) years.

Client name: Services rendered: Total gross billings: \$
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Client name: Services rendered: Total gross billings: \$
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Client name: Services rendered: Total gross billings: \$
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16. Does the Applicant utilize the services of independent contractors or sub-consultants? Yes No
 a. Approximate percentage of billings attributable to independent contractors or sub-consultants: %
17. Does the Applicant ever enter into contracts where their fees for services provided are contingent upon the client achieving cost reductions or improved operating results? Yes No
If yes, provide a detailed description of such arrangements.
18. Does the Applicant secure a written contract or agreement for every project? Yes No
(Please attach a sample copy)
If no, provide the percentage of your gross annual revenue where a written contract is secured: %
 a. Does the Applicant's contract contain any of the following? **(check all that apply)**
 Hold harmless or indemnification clauses in your favor Guarantees or warranties
 Hold harmless or indemnification clauses in your clients favor Payment terms
 A specific description of the services you will provide
19. Describe steps taken to minimize / manage business risks:
20. Has any policy or application for similar insurance on your behalf or on the behalf of any of your principals, partners, officers, employees, or on behalf of any predecessors in business ever been declined, canceled, or renewal refused? Yes No
If yes, provide details. NOT APPLICABLE IN MISSOURI
21. Does the Applicant currently carry commercial general liability insurance? Yes No
22. Has the Applicant sued to collect past or overdue fees from clients within the past 2 years? **If yes, please provide details on the Additional Information page below.** Yes No
23. Please provide the following information on your professional liability (E&O) insurance for the past three (3) years:
- | | | | |
|------------------|-------------|------------------------|---|
| Name of Insurer: | | Limit of Liability: \$ | |
| Deductible: \$ | Premium: \$ | Policy period: | - |
| Name of Insurer: | | Limit of Liability: \$ | |
| Deductible: \$ | Premium: \$ | Policy period: | - |
| Name of Insurer: | | Limit of Liability: \$ | |
| Deductible: \$ | Premium: \$ | Policy period: | - |
- a. Retro-active date on current policy:
24. Have any claims, suits, or demands for arbitration been made against the Applicant, its predecessor(s) or any past or present principal, partner, officer or employee within the past five (5) years? Yes No
If yes, complete a Claim Supplement form for each incident.
25. Having inquired all principals, partners and officers, are you aware of any act, error, omission, unresolved job dispute or any other circumstance that is or could be a basis for a claim under the proposed insurance? Yes No
If yes, complete a Claim Supplement form for each incident.

26. Please indicate the number of claim supplemental forms attached to this application:

With regard to questions 24. and 25., it is understood and agreed that if any such claim, act, error, omission, dispute or circumstance exists, then such claim and/or claims arising from such act, error, omission, dispute or circumstance is excluded from coverage that may be provided under this proposed insurance and, further, failure to disclose such claim, act, error, omission, dispute or circumstance may result in the proposed insurance being void, and/or subject to rescission.

Coverage requested:

LIMIT OF LIABILITY:					
\$250,000	\$1,000,000	\$4,000,000	\$7,000,000	\$10,000,000	
\$300,000	\$2,000,000	\$5,000,000	\$8,000,000		
\$500,000	\$3,000,000	\$6,000,000	\$9,000,000		
DEDUCTIBLE:	\$				

Attach the following items in support of this application

1. Applicant Firm's **statement of qualifications** including resumes of all key (technical) personnel along with any available marketing material or company brochures.
2. A copy of the Applicant Firm's formalized **standard client contract**.
3. A copy of the outline from the Applicant Firm's **Quality Assurance / Quality Control (QA/QC) manual**.

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.

*Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

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 THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (NOT APPLICABLE IN AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OK, PA, RI, TN, VA, VT, WA AND WV).

NAME (PLEASE PRINT/TYPE)

TITLE

(MUST BE SIGNED BY THE PRINCIPAL, PARTNER, OR OFFICER)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER

(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER

(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

ADDITIONAL INFORMATION

This page may be used to provide additional information to any question on this application. Please identify the question number to which you are referring.

Signature

Date