



St. Paul Travelers 1ST ChoiceSM
Life and Health Insurance Agents or Brokers
Professional Liability Insurance Claims Made Application

- St. Paul Fire and Marine Insurance Company, Saint Paul, Minnesota**
- St. Paul Mercury Insurance Company, Saint Paul, Minnesota**
- St. Paul Guardian Insurance Company, Saint Paul, Minnesota**
- St. Paul Protective Insurance Company, Saint Paul, Minnesota**

IMPORTANT NOTE: This is an application for a policy which, if issued, will be on a claims-made basis. To be covered, CLAIMS must be first made against the INSUREDS and reported during the POLICY PERIOD or applicable extended reporting period. Also, the limits of liability of any such policy may be reduced by amounts paid for DEFENSE COSTS, and such payments for DEFENSE COSTS may also be applied against the deductible amount, unless we agree otherwise.

NY DEFENSE COSTS NOTICE: If this policy contains an insuring agreement that includes DEFENSE COSTS within the limits of coverage, and/or a deductible that applies to DEFENSE COSTS, 100% of such limit or deductible may be used up with the payment of CLAIMS or DEFENSE COSTS. Once the limit of coverage is used up, we will have no further obligation to pay any "damages" or "claims expenses".

Agent's Name:	Agent's License ID No.
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IMPORTANT - ANSWER ALL QUESTIONS IN INK - Incomplete applications cannot be processed.

1. Legal Name(s) of Agency (dba)	
2. Address (City, State, Zip Code)	
3. Phone	4. Fax
5. Address of Subsidiaries/Branch Offices	
6. Ownership Structure <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation	7. Date Established (If less than three years, provide resume for each principle)

8. a. Total gross revenues last year (New and Renewal)..... \$ _____

b. Estimated next year (New and Renewal) \$ _____

(Include all commission income and fees before deduction of expenses)

9. Please give the approximate percentage breakdown of Total Business of Agency:

a. Agent (Personal Producing)..... _____%	e. Brokerage General Agency* _____%
b. General Agent (P.P.G.A.) _____%	f. Managing General Agency* _____%
c. Broker..... _____%	g. Consultant (for fee)* _____%
d. Life Co. General Agency* _____%	h. Other*

TOTAL _____%

(Items A-H must total 100%)

* Provide written description of activities

10. Full Names of Life/Accident & Health Companies and % of total business with each:

1st _____ %	3rd _____ %
2nd _____ %	4th (Total of all other companies) _____ %

If more than 30%, provide name and rating of next 4 carriers.

11. Percentage of the Agency's total business activities in consulting, sales and service of:
(Based on income received):

% Breakdown
(if none, write 0%)

- a. "FULLY INSURED" Life and annuity policies (individual and group) issued by licensed Life Companies %
- b. "FULLY INSURED" Health, A&H, and Medical policies (individual and group) issued by licensed Life/A&H Companies, Regulated HMOs or Service Plans (Blue Cross/Shield) %
- c. Administration of "FULLY INSURED" benefit plans or pension plans* %
- d. Claims administration of "FULLY INSURED" benefit plans* %
- e. Property/Casualty (Auto, Homeowner, Liability) %
- f. Workers' Compensation (including 24 hour coverage in California) %
- g. Mutual Funds Sales (exclusive of Annuity/Group or Employee Benefit Plans) %
- h. "Self Insured or Self Funded" (Employee Benefits, Pension, and/or Medical plans)* %
- i. All other business activities (Explain using separate sheet)* %

**Please provide a detailed description including carrier names. Use separate sheet.*

TOTAL %

Business Activities must total 100%

12. Complete only if applying for optional property/casualty coverage.

- a. Applicant's total annual property/casualty commissions (included in #8): (New and Renewal) \$ _____
 - Aviation % Personal Lines %
 - Commercial Property & Liability % Professional Liability %
 - Bonds % Other (describe) %
- b. Excluding pool business, provide the percentage of applicant's business which is placed with non-admitted carriers %
- c. Percentage of sub-produced business the applicant places %

13. Declarations of "LICENSED" persons (include yourself) whether owners, partners, directors, officers, stockholders or employees (selling or not). Type of Licenses – Check all that apply and indicate date first obtained.

a. LICENSED PERSONS	Designation Code*	Life Date	Health Date	P/C Date	SEC Type And Series Date

(If necessary, use separate sheet)

**Designation Codes: O=Owner, P=Partner, OF=Officer/Director, E=Employee, IC=Independent Contractor*

- b. UNLICENSED staff *(total number)* _____
1. Full time..... _____
1. Part time _____
- c. Number of sub-agents, brokers, independent contractors? *(total number)**..... _____

***NOTE:** *Not covered unless added as Additional Insureds for an additional premium to cover them only for business placed with your Agency. If you desire coverage for these individuals, please identify them by name and include their revenues on your letterhead.*

Note: If the applicant answers “yes” to any of the following questions (14-19), you must provide explanations under question 25 Supplemental Answers or claim form.

14. a. Has any prospective insured ever had his/her license revoked or suspended or been fined or disciplined in any way by a state insurance department? Yes No
If yes, please attach copies of any letters or court orders.
- b. Has any policy of or application for similar insurance on the agency’s behalf or any of its partners, executive officers, directors, salespersons (whether employees or independent contractors), employees, or on behalf of any predecessors in business ever been declined, cancelled or nonrenewed? Yes No
(Not applicable in Missouri)

15. E&O coverage for last 3 years? **(NEW APPLICANTS ONLY)**

Carrier	Limits	Deductible	Expiration Month Day Year	Annual Premium	Extended Claim Reporting Period Purchased
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

16. Have any professional liability (E&O) claims been made during the past five years against the agency or any of its past or present partners, executive officers, directors, salespersons (whether employees or independent contractors), employees, or any predecessors in business? Yes No
If yes, please complete a supplemental claim form for each claim.
17. Does any prospective insured have knowledge or information of any circumstances or any allegations or contentions of any incident which may result in any claim being made against the agency or any of its past or present partners, executive officers, directors, salespersons (whether employees or independent contractors), employees, or any predecessors in business?..... Yes No
If yes, please complete a supplemental claim form describing the incident.
Claims made, or potential claims that you are aware of, prior to a policy’s inception are not covered.
18. Is the agency engaged in, owned by, associated with or controlled by any other business? Yes No
- a. Are You or Your Agency affiliated or associated with, or represent any other Agency or Brokerage? Yes No
- b. Are there any OTHER “LICENSED” persons whether owners, partners, directors, officers, stockholders, or employees? Yes No
- c. Are there any other Agents or Sub-Agents (“Independent Contractors”) who represent You or Your Agency or Firm? Yes No
19. During the past five (5) years, has the name of the agency been changed or has any other business purchased, merged or consolidated with the agency? Yes No
If yes, please provide complete details, including prior insurance and claim history.

ARKANSAS: 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.

COLORADO: 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 agencies.

DISTRICT OF COLUMBIA: 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.

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.

HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

KENTUCKY: 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.

LOUISIANA: 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.

MAINE: 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.

MINNESOTA: A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK (Non Auto): 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.

OHIO: 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.

OKLAHOMA: 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.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

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 THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

VERMONT: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WEST VIRGINIA: 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.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and civil penalties. Not applicable in Nebraska.

YOUR SIGNATURE AND AUTHORIZATION

The undersigned authorized representative of the firm, or individual if this application is for an individual, agrees to all to the following:

- The statements and representations made in this application are true and complete and will be deemed material to the acceptance of the risk assumed by St. Paul Travelers in the event an insurance policy is issued.
- If the information supplied in this application changes between the date of the application and the effective date of any insurance policy issued by St. Paul Travelers in response to this application, you will immediately notify us of such changes, and we may withdraw or modify any outstanding quotation or agreement to bind coverage.
- St. Paul Travelers is authorized to make an investigation and inquiry in connection with this application.
- St. Paul Travelers is not bound or obligated to issue any insurance policy or to provide the insurance requested in this application.

Signature (<i>Partner, Member, Officer, Proprietor</i>)	Title	Date
Print name	Name of Firm	

Important Note: This application is not a representation that coverage does or does not exist for any particular claim or loss, or type of claim or loss, under any insurance policy issued by St. Paul Travelers. Whether coverage exists or does not exist for any particular claim or loss under any such policy depends on the facts and circumstances involved in the claim or loss and all applicable wording of the policy actually issued.

Please send completed forms to Marsh Affinity Group Services, P.O. Box 8146, Des Moines, IA 50301-8146, Telephone: 888-424-2310, Fax: 515-243-2331

INSTRUCTIONS:

- 1. DO NOT SEND SUIT PAPERS.**
- 2. This form is to be completed on behalf of each proposed Insured who has been involved in any claim or suit or who is aware of an incident which may give rise to a claim. **Complete one form for each claim or incident.**
- 3. If the space provided is insufficient to answer all questions fully, please attach a separate sheet.
- 4. Please answer all questions completely.

(PLEASE TYPE OR PRINT)

1. Full name of Agency: _____

2. Full name of individual(s) involved in the claim or incident: _____

3. Full name(s) of Claimant(s) or potential Claimant(s): _____

4. This is a: Claim Suit Incident

5. Date and location of act, error or omission alleged or which may be alleged: _____

6. Date of Claim: _____

7. Additional defendant(s) or potential defendant(s): _____

8. If this is a CLOSED matter:
- a. Total loss paid including deductible(s) \$ _____
 - b. Indicate whether: Court Judgment
 Out of Court settlement

9. If this is a PENDING matter, please indicate:
- a. Claimant's settlement demand: \$ _____
 - b. Defendant's offer for settlement: \$ _____

10. Name(s) of Insurer(s) responding to this claim or incident: _____

11. Description of claim, Suit or Incident.

a. Description of alleged act, error or omission upon which claim is or may be based:

b. Description of the type and extent of injury or damage which is or may be alleged to have been sustained:

c. Explain what action(s) have been taken to prevent recurrence of same or similar claim:

FRAUD WARNING [Not applicable in Colorado, Hawaii, Nebraska, Ohio, Oklahoma, Oregon, Utah, or Vermont]: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

COLORADO FRAUD WARNING: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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 Agencies.

HAWAII FRAUD WARNING: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

OHIO FRAUD WARNING: Any person who, with intent to defraud or knowing that he/she 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.

OKLAHOMA FRAUD 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.

YOUR SIGNATURE AND AUTHORIZATION

The undersigned authorized representative of the firm, or individual if this application is for an individual, agrees to all to the following:

- The statements and representations made in this application are true and complete and will be deemed material to the acceptance of the risk assumed by St. Paul Travelers in the event an insurance policy is issued.
- If the information supplied in this application changes between the date of the application and the effective date of any insurance policy issued by St. Paul Travelers in response to this application, you will immediately notify us of such changes, and we may withdraw or modify any outstanding quotation or agreement to bind coverage.
- St. Paul Travelers is authorized to make an investigation and inquiry in connection with this application.
- St. Paul Travelers is not bound or obligated to issue any insurance policy or to provide the insurance requested in this application.

Signature (<i>Partner, Member, Officer, Proprietor</i>)	Title	Date
Print name	Name of Firm	

Important Note: This application is not a representation that coverage does or does not exist for any particular claim or loss, or type of claim or loss, under any insurance policy issued by St. Paul Travelers. Whether coverage exists or does not exist for any particular claim or loss under any such policy depends on the facts and circumstances involved in the claim or loss and all applicable wording of the policy actually issued.

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**QUESTION 11h – SELF-INSURED – SELF-FUNDED
QUESTIONNAIRE**

Name of Applicant: _____

1. How many years experience do you have providing this type of service? _____

2. Provide the name(s) of the insurer(s)/reinsurer(s) you use to place stop-loss coverage and their current AM Best's ratings. _____

3. Provide **a.** Number of accounts placed: _____ **b.** Number of lives covered: _____
4. What services do you provide? _____

5. Do you have any TPA duties? _____ If yes, please provide complete details. _____

6. Do you provide any underwriting, plan or claim administration? _____ If yes, please provide complete details. _____

7. Who administers the plan(s)? _____

8. Who designs the plan(s)? _____

9. Provide complete details on how each plan is constructed. Is any portion of the stop loss coverage not funded entirely by insurance or reinsurance (i.e., is there any coinsurance or proportionate share in the stop loss coverage that is other than 100% insurance or reinsurance)?

10. Do you provide any services for Multiple Employer Trusts or Multiple Employer Welfare Arrangements? _____ If yes, please provide full details.

Signature of Sole Proprietor, Partner, Director or Officer **Title** **Date**