TRAVELERS

Insurance Professionals Liability Coverage
Life, Health and Accident Insurance Agents or Brokers
Professional Liability Insurance Claims-Made Renewal
Application

St. Paul Fire and Marine Insurance Company

Claims-Made: The information requested in this Application is for a Claims-Made policy. If issued, the policy will apply only to claims first made during the policy period, or any applicable extended reporting period.

Defense Within Limits: The limits of liability will be reduced, and may be completely exhausted, by amounts paid as defense expenses, and any deductible will be applied against defense expenses. The Insurer will not be liable for the amount of any judgment, settlement, or defense expenses incurred after exhaustion of the limit of liability. (For policies issued in New York, the limit of liability may be reduced up to 50% for amounts paid as defense expenses, and the deductible may apply up to 50% of defense expenses.)

If the name differs from the full legal name of the Applicant, provide detail on a separate attachment.

GENERAL INFORMATION

Full Legal Name of Applicant:

Trade or Doing Business As Name:

Street Address:

City:		State:	Zip:
Primary Contact Name and Title:	Phone:	Fax:	Date Established:
Email Address:	Website Address:		

Ownership Type:
☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ LLP ☐ Other:

DESCRIPTION OF OPERATIONS

1. Do you have any subsidiaries or branch offices? ☐ Yes ☐ No
   If Yes, provide the addresses of each office (use a separate sheet if needed).

2. Are you or any member of your firm a member of NABIP? ☐ Yes ☐ No
   If Yes, provide member name:

3. Are you or any member of your firm a member of any other insurance professional organization? ☐ Yes ☐ No
   If Yes, describe:

4. Since the completion of your last application:
   a. Have you changed the name of the agency or has the agency merged with, acquired, or been acquired by another agency/company? ☐ Yes ☐ No
   b. Have you changed your address, telephone, fax numbers or added additional locations? ☐ Yes ☐ No
   c. Is any Insured engaged in any other business operations, or conduct any business under any other name? ☐ Yes ☐ No

   If Yes to a., b. or c. above, provide complete details on a separate sheet.

   d. Are you aware of any circumstance, allegation, contention or incident which may result in a claim being made against the agency or any of its representatives that has not already been reported to Travelers? ☐ Yes ☐ No

   If Yes, complete the Supplemental Claim Form.

e. Has any Insured had any license revoked or suspended or been fined or disciplined in any way by a state insurance department or other regulatory or licensing body? ☐ Yes ☐ No

If Yes, provide details on a separate sheet and a copy of the ruling.

BUSINESS BREAKDOWN

5. Provide the gross annual commission and fee revenue from life and health products and services provided by your agency (revenue is based on commission income and fees before deduction of expenses). Include commission or revenue that is paid by your insurance carriers directly to your non-employee producers including sub-agents, brokers, and independent contractors for business that is placed through your agency. (Also include commission or fee revenue from mutual funds if you are requesting this optional coverage.)

   Revenue for the past 12 months: $ _____

   Estimated revenue for next year (new and renewal): $ _____

6. Give the approximate percentage breakdown of the total business that is placed by you or your agency as a(n):

Agent (Personal Producing)	%	Brokerage General Agency	%
Broker (Personal Producing)	%	Managing General Agency	%
General Agent (P.P.G.A.)	%	Consultant (for fee)	%
Life Co. General Agent	%	Other (describe on separate sheet)	%

7. Break down your total revenues by percentage of professional activities during the past year. Total must equal 100% of total gross revenues in question 5 above. Provide a detailed explanation where required, attaching additional sheets if necessary.

   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: _____ %

      Describe: _____

   d. COBRA administration or services: _____ %

   e. Claims administration of fully-insured benefit plans: _____ %

      Describe: _____

   f. Property and casualty insurance (except California 24-hour worker's compensation): _____ %

      If you desire coverage for property and casualty professional liability, you will need to complete the Property and Casualty Professional Liability Insurance Supplement.

   g. California 24-hour type worker's compensation: _____ %

   h. Mutual fund sales (exclusive of annuity/group or employee benefit plans): _____ %

   i. Self-insured or self-funded employee benefits, pension, and/or medical plans: _____ %

      Complete the Self-insured/Self-funded Business Supplement if you show any percentage here.

   j. All other business activities: _____ %

      Describe: _____

   Business Activities must total 100% **TOTAL** **100**%

Optional coverage for Mutual Funds and Property and Casualty Insurance is available under this policy. See question 17.

8. Provide the full names of life/accident & health companies and % of total business with each:

1st		%	4th		%
2nd		%	5th		%
3rd		%	6th	(total of all other companies)	%

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

PRODUCTION SOURCES

9. List all actively licensed persons who represent your agency. (All licensed persons including independent contractors must be named in order for coverage to apply to that individual.) **Include any sub-agents/independent contractors that you wish to include under your coverage for business that they place through your agency**. Attach a separate list if necessary.

		Licensed for: check all that apply and include the date first licensed				
*Licensed Persons	**Designation Code	LIFE	A&H	P&C	SEC (type/series #)	Professional Designations Held
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		

**Place an asterisk next to the name of any person licensed in Kentucky.*

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

10. Indicate the number of unlicensed support staff employees: _____

11. Do you or your agency or any owner, partner or officer place business for, receive production from, or receive revenue based on the production of any non-employee producer, including sub-agents, independent contractors or other agents or brokers? ☐ Yes ☐ No

If Yes, complete the Sub-agent/Independent Contractor/Non-employee Producer Supplement.

12. Indicate the percentage of your total business received:

Direct from your Insureds: _____ %

From other agents, brokers or non-employee producers who receive payment from you or from your carriers for this business: _____ %

13. List all states where licenses are held by you or anyone in your agency:

_____

_____

LOSS CONTROL QUESTIONS

14. Do you maintain a written office procedure manual? ☐ Yes ☐ No

If Yes, does it contain the following:

a. Procedures for handling all business transactions ☐ Yes ☐ No
b. File documentation requirements ☐ Yes ☐ No
c. Agency diary and recall procedures ☐ Yes ☐ No
d. Job descriptions/responsibilities for each employee ☐ Yes ☐ No
e. Guidelines for carrier ratings ☐ Yes ☐ No
f. Company Information ☐ Yes ☐ No
g. Agency statement regarding training and education ☐ Yes ☐ No
h. Role of the computer in the agency ☐ Yes ☐ No

15. Have you attended a Sponsored Loss Control Seminar in the past 12 months? (NABIP, NAIFA, PIA, IIA) ☐ Yes ☐ No

If Yes, specify who attended: # of principals: _____ # Staff/CSR: _____

COVERAGE REQUEST

16. Check the coverage limits and desired deductible:

Note: the $100,000/$300,000 limit option and $1,000 deductible is only available to firms with revenue less than $75,000. Availability of some Limit and Deductible options may be subject to underwriting and regulatory restrictions.

Coverage limits	Deductible
☐ $100,000/$300,000	☐ $1,000 (minimum)
☐ $250,000/$750,000	☐ $2,500
☐ $500,000/$1,500,000	☐ $5,000
☐ $1,000,000/$3,000,000	☐ $7,500
☐ Other:$ _____	☐ $10,000
	☐ Other:$ _____

17. The following professional coverages can be added to the policy for an additional premium charge. Indicate each coverage desired.

☐ Mutual Funds

☐ Property and Casualty

If you desire coverage for property and casualty professional liability, you will need to complete the Property and Casualty Professional Liability Insurance Supplement. Coverage is subject to underwriting consideration.

NOTICE REGARDING COMPENSATION

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KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND 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 such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

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SIGNATURES

The undersigned Authorized Representative represents that to the best of their knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and, except in North Carolina, may be relied upon by Travelers as the basis for providing insurance. The Applicant will notify Travelers of any material changes to the information provided.

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Authorized Representative Signature: **X**	Authorized Representative Name and Title:	Date *(month/dd/yyyy)*:
Producer Name (required in FL & IA): **X**	State Producer License No (required in FL):	Date *(month/dd/yyyy)*:
Agency:		Agency Phone Number:

TRAVELERS

Insurance Professionals Liability Coverage
Life, Health and Accident Insurance Agents or Brokers
Property and Casualty Professional Liability Insurance
Supplement

St. Paul Fire and Marine Insurance Company

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Complete the following only if property and casualty professional liability coverage is desired. If more forms are needed, make a copy of this supplement before completing.

GENERAL INFORMATION

Full Legal Name of Applicant:	Policy Number:

DESCRIPTION OF OPERATIONS

1. In the table below provide the dollar amounts of annual property and casualty revenue. This revenue should be included in the gross annual revenue amount of the Life and Health Application (new and renewal):

	Last Fiscal Year	Estimated Next Year
Gross property/casualty annual revenues (prior to expenses/deductions)	$	$

2. Provide the total annual gross revenue from substandard property and casualty business: $

   (Including surcharged auto, assigned risk auto, assigned risk pools for auto, workers compensation, property, etc.)

3. Provide the approximate percentage breakdown of total property and casualty annual revenue for business placed as:
   a. An agent (with or without binding authority): %
   b. A broker (through other agents): %
   TOTAL **100%**

4. Give the approximate percentage breakdown of annual property and casualty revenue for business received or assumed:
   a. Direct from Insureds: %
   b. From other agencies, brokers or non-employee producers who receive payment from you or your carriers for this business: %
   TOTAL **100%**

5. Indicate the approximate annual revenue of the applicant's total property and casualty business for each category below. The total annual property and casualty revenue for your agency must be accounted for below:

Lines of Business/Area of Operations	Total Annual Revenue	Lines of Business/Area of Operations	Total Annual Revenue
COMMERCIAL LINES:		PERSONAL LINES:	
Automobile - Standard	$	Automobile - Standard	$
Automobile - Non-Standard	$	Automobile - Non-standard/Plan/CAR	$
Automobile - Long Haul Trucking	$	Homeowners	$
Aviation	$	Standard Fire	$
Animal/Livestock Mortality	$	Non-Standard Fire	$
Crop Insurance	$	Other Personal Lines business (specify)	$
Bonds	$	Total Personal Lines Revenue	$
Executive Liability, D&O	$		
Professional Liability (specify)	$		
Ocean or Inland Marine (specify)	$	OTHER P&C OPERATIONS/SERVICES REVENUES:	
Excess and Surplus Lines	$	Consulting	$
Businessowners Package	$	Loss Control/Risk Management	$
Commercial Package	$	Claims Adjusting/Administration	$
Commercial General Liability (CGL)	$	OSHA/Environmental Audits	$
Fire - Standard	$	Certified Training Programs	$
Fire - Nonstandard (Fair Plan)	$		
Flood Insurance	$		
Workers Compensation (other than California 24-hour compensation)	$	Actuarial Services	$
Other Commercial business (specify)	$	Other Services/Operations (explain)	$
Total Commercial Revenue	$	Total Other Ops/Services Revenue	$

6. Provide the approximate annual property and casualty revenue for business written on a non-admitted or surplus lines basis: $

   a. Is the applicant a licensed surplus lines broker? ☐ Yes ☐ No

7. List all insurance companies that business is placed with by the applicant which accounts for 100% of your total property and casualty revenue. (Attach a separate sheet if necessary.) Insurance company includes any reinsurer, syndicate, association, or any other organization formed for the purposes of providing insurance or reinsurance.

Company Name	Binding Authority (Yes/No)	Current A.M. Best Rating	Percent of Total Revenue
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%
	☐ Yes ☐ No		%

8. List all property and casualty companies that either the applicant or company has terminated the relationship with during the past five (5) years and reason for termination. *If none check here* ☐.

Company Name	Date of Termination	Reason for Termination

9. List the property and casualty insurance agents or brokers professional liability insurance carrier for the past five (5) years. *Check here if no insurance* ☐

Insurance Company	Limit of Liability	Deductible or Retention	Policy Period	Retroactive Date, if any	Premium
	$	$	to		$
	$	$	to		$
	$	$	to		$
	$	$	to		$
	$	$	to		$

10. During the past five (5) years, has any insurance carrier declined, cancelled, or refused to renew the applicant's Property and Casualty liability insurance for any reason? *(Missouri applicants: Do not complete)* ☐ Yes ☐ No

    If Yes, provide complete details including the name of the carrier, the date and reason for declination, cancellation or non-renewal on a separate sheet attached to this supplement.

11. After inquiry, is any owner, officer, principal, partner, manager or supervisor of the applicant aware of:
    a. Any property and casualty liability insurance claims against them, the applicant firm, or predecessor firm during the past five (5) years? ☐ Yes ☐ No
    b. Any services or incidents that might reasonably be expected to lead to a property and casualty liability insurance claim or suit against them, the applicant firm or a predecessor firm? ☐ Yes ☐ No

    If Yes, to either question, complete a Supplemental Claim Form.

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TRAVELERS

Insurance Professionals Liability Coverage
Life, Health and Accident Insurance Agents or Brokers
Sub-Agent/Independent Contractor/Non-Employee
Producer Supplement

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Complete the following only if you place business for or derive revenue from sub-agents, independent contractors or non-employee producers.

GENERAL INFORMATION

Full Legal Name of Applicant:	Policy Number:

DESCRIPTION OF OPERATIONS

1. Indicate the number of sub-agents, brokers, independent contractors or non-employee producers that place business through your agency during the past 12 months: _____

2. Are your sub-agents, brokers, independent contractors or non-employee producers compensated by you or are they paid commissions directly from your carriers?
   ☐ Compensated directly by you ☐ Compensated directly by Carrier ☐ Both

3. For business placed through your agency, Indicate the total sub-agent, broker, independent contractor or non-employee producer annual compensation:
   a. Paid directly to non-employee producers by the insurance carriers or providers: $ _____
   b. Paid to non-employee producers by you or your agency: $ _____
   (These amounts should be included in the total revenue listed on your application.)

4. For your sub-produced business indicate:
   a. Average over-ride commission you receive: _____ %
   b. Average commission paid to non-employee producers: _____ %

5. Do you or your insurance carriers require your non-employee producers, sub-agents/brokers have a professional liability insurance policy of their own? ☐ Yes ☐ No

6. Do you or your insurance carriers obtain evidence each year that all your sub-agents/brokers carry professional liability insurance coverage? ☐ Yes ☐ No
   a. If Yes, do you or your insurance carriers require your non-employee producers to maintain professional liability insurance limits of at least $1,000,000 each claim with a carrier rated A- or better by A.M. Best Company? ☐ Yes ☐ No

7. Do you provide periodic training sessions and/or educational seminars to your non-employee producers, independent contractors or sub-producers relevant to product information, client services and risk management? ☐ Yes ☐ No
   If Yes, provide a brief description of these training seminars and their frequency below.

8. Furnish a brief narrative description of the services and training your firm provides to non-employee producers.

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Agency:		Agency Phone Number:

TRAVELERS

Insurance Professionals Liability Coverage
Life, Health and Accident Insurance Agents or Brokers

St. Paul Fire and Marine Insurance Company

Self-Insured/Self-Funded Business Supplement

Claims-Made: The information requested in this Application is for a Claims-Made policy. If issued, the policy will apply only to claims first made during the policy period, or any applicable extended reporting period.

Defense Within Limits: The limits of liability will be reduced, and may be completely exhausted, by amounts paid as defense expenses, and any deductible will be applied against defense expenses. The Insurer will not be liable for the amount of any judgment, settlement, or defense expenses incurred after exhaustion of the limit of liability. (For policies issued in New York, the limit of liability may be reduced up to 50% for amounts paid as defense expenses, and the deductible may apply up to 50% of defense expenses.)

Complete the following only if you receive revenue from your sales or activities involving self-insured or self-funded employee benefit plans, pension and/or medical plans.

GENERAL INFORMATION

Full Legal Name of Applicant: | Policy Number:

DESCRIPTION OF OPERATIONS

1. Provide the number of years experience you have been providing this type of service/activity: _____

2. Provide the name(s) and current A.M. Best Company ratings for the insurer(s) or reinsurer(s) you use to place stop-loss coverage.

   _____

   _____

3. Provide the number of:
   a. Accounts placed _____
   b. Lives covered _____

4. Indicate the services you provide for each plan: _____

   _____

   _____

5. Do you have any TPA duties? ☐ Yes ☐ No

   If Yes, provide complete details regarding your TPA activities: _____

   _____

   _____

6. Do you provide any underwriting, plan or claim administration? ☐ Yes ☐ No

   If Yes, provide complete details regarding these activities: _____

   _____

   _____

7. Indicate who administers the plan(s): _____

   _____

   _____

8. Indicate who develops or designs the contract for the plan(s): _____

9. Provide complete details of how each plan is constructed, i.e., self-funded amount/stop loss protection:

10. Indicate if the stop loss coverage is:
    - ☐ Fully funded 100% by insurance or reinsurance, or
    - ☐ Partially funded by insurance or reinsurance with the plan purchaser(s) or participants responsible for a coinsurance portion or proportionate share of the stop loss coverage.

11. Do you provide any services for Multiple Employer Trusts or Multiple Employer Welfare Arrangements? ☐ Yes ☐ No

    If Yes, provide complete details of these services: _____

NOTICE REGARDING COMPENSATION

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Agency Compensation, One Tower Square, Hartford, CT 06183.

FRAUD STATEMENTS – ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company to defraud or attempt 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 to defraud or attempt to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds will be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND 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 such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company to defraud the company. Penalties include imprisonment, fines, and denial of insurance benefits.

OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

PUERTO RICO: Any person who knowingly and intending to defraud presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, will incur a felony and, upon conviction, will be sanctioned for each violation with the penalty of a fine of not less than $5,000 and not over $10,000, or a fixed term of imprisonment for three years, or both penalties. Should aggravating circumstances be present, the penalty established may be increased to a maximum of five years; if extenuating circumstances are present, it may be reduced to a minimum of two years.

SIGNATURES

The undersigned Authorized Representative represents that to the best of their knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and, except in North Carolina, may be relied upon by Travelers as the basis for providing insurance. The Applicant will notify Travelers of any material changes to the information provided.

☐ Electronic Signature and Acceptance – Authorized Representative*

*If electronically submitting this document, electronically sign this form by checking the Electronic Signature and Acceptance box above. By doing so, the Applicant agrees that use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes acceptance and agreement as if signed in writing and has the same force and effect as a signature affixed by hand.

Authorized Representative Signature: **X**	Authorized Representative Name and Title:	Date *(month/dd/yyyy)*:
Producer Name (required in FL & IA): **X**	State Producer License No (required in FL):	Date *(month/dd/yyyy)*:
Agency:		Agency Phone Number:

TRAVELERS

Insurance Professionals Liability Coverage
Life, Health and Accident Insurance Agents or Brokers

St. Paul Fire and Marine Insurance Company

Supplemental Claim Form

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INSTRUCTIONS

Answer all questions completely. This supplement is to be completed on behalf of each applicant who has been involved in any claim or who is aware of any incident that may give rise to a claim. Complete one supplement for each claim or incident. If the space provided is insufficient to answer all the questions fully, please attach a separate sheet. Do not send suit papers.

CLAIM/INCIDENT INFORMATION

1. Full Legal Name of Applicant:

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, 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:

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Authorized Representative Signature: **X**	Authorized Representative Name and Title:	Date *(month/dd/yyyy)*:
Producer Name (required in FL & IA): **X**	State Producer License No (required in FL):	Date *(month/dd/yyyy)*:
Agency:		Agency Phone Number: