

WKF&C Agency

**APPLICATION FOR INSURANCE AGENTS AND BROKERS PROFESSIONAL
LIABILITY INSURANCE POLICY**

1. Named Insured _____

DBA (if any) _____

Home Office Mailing Address _____

Physical Address _____

Phone _____ Email _____

Additional Locations _____

2. Date Established _____

If in operation less than (3) years, please attaché license(s) and resume(s) for all Principals.

Form of Individual:

Corporation

Partnership

Other _____

Is the applicant firm controlled, owned (in whole or part), affiliated or associated with any other firm, corporation, company or entity? Yes No

If Yes, please explain relationship: _____

3. During the past 5 years:

a) Has the name of the firm been changed, or has any business/firm been acquired, merged into, consolidated or sold off by/from the original firm? Yes No

If yes, please explain and provide name (s) of predecessor firm(s) _____

4. Is there any entity(s) having a 10% or greater interest in the Applicant, any subsidiary and/or affiliate of the Applicant? Yes No

If Yes, please provide the entity's name, % ownership interest and relationship to Applicant.

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

c. Have there been any cluster arrangements? Yes No

If Yes, please explain _____

5. a. List the current top five (5) insurance companies for whom you produce premium.

Insurance Company Name	Years Represented	Annual Premium Volume
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. What percent of business is placed with: Admitted Carriers: ____% Non Admitted Carriers ____%

6. a. List ALL insurance companies, currently rated NR or B+ or less by A.M. Best for which you placed business over the last three (3) years.

Insurance Company Name	Years Represented	Annual Premium Volume
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. List all insurance companies with whom agency contracts have been terminated in the last 5 years and provide a reason for each termination. (if none, state "none") _____

7.

		Previous 36 months	Previous 24 months	Current 24 months	Estimated Next 12 Months
a.)	Total P&C gross written annual premium:				
b.)	Total gross annual P&C commissions:				
c.)	Total Life and A&H gross written premium				
d.)	Total gross annual life and A&H commissions				
e.)	Total annual income derived from other insurance related activities.				

8.

COMMERCIAL LINES	PERSONAL LINES
CMP/Package	Auto-Standard
CGL/BOP	Auto-Non Standard
Umbrella/Excess	Homeowners
Auto-Standard	Pleasure Boats
Long Haul Trucking	Mobile Homes/RVs
Workers Compensation	Motorcycles
Livestock Mortality	Wind/Flood/EQ
Crop Coverages	Umbrella
Medical Malpractice	Other (specify)
Professional Liability – (specify)	TOTAL PERSONAL LINES
Wet Marine	
Inland Marine	LIFE AND A&H INSURANCE
Bonds/Surety	Life/Individual
Aviation	Life, Group
Products Liability	A&H, Individual
Other (specify)	A&H, Group
TOTAL COMMERCIAL LINES	Annuities
	HMO/PPO/DSP
	Other (Specify)
	TOTAL LIFE AND A&H

b.) Property and Casualty Business Placed As:

Agent (business placed directly with carriers)	%
Broker/Wholesaler	%
Managing General Agent/Underwriter	%
Reinsurance Intermediary	%
Surplus Lines Broker	%

- c.) Percentage of policies written on a direct bill basis: _____ %
d.) Percentage of gross written premium placed through a service center: _____ %
e.) Percentage of gross written premium placed through a state administered fund _____ %
f.) Percentage of business written through MGA's, other brokers or intermediaries _____ %

9. Does the Applicant perform any of the following activities: if yes, attach resume(s), promotional materials and sample contract(s).

a. Reinsurance Intermediary	Yes	No	\$ _____
b. Third Party Administrator	Yes	No	\$ _____
c. Claims Adjustment Services	Yes	No	\$ _____
d. Actuarial Services	Yes	No	\$ _____
e. Legal Advisor/Services	Yes	No	\$ _____
f. Risk Management/Loss Control	Yes	No	\$ _____
g. Title Insurance	Yes	No	\$ _____

If Yes is indicated for b or c, a Third Party Administration and Claims Administrative Services Supplemental Application MUST be completed and attached to this Application.

10. In the past five (5) years, has the Applicant:

- a. Specialized in any programs or classes of business: Yes No
b. Placed coverage or been involved in Self Insured/Captives, Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), Or Multiple Employer Trusts (MET)? Yes No

If either of the above are answered Yes, please attach an explanation, including the name of the program(s), carrier(s), extent of coverage(s) provided, administrative duties performed by the Applicant, and any applicable financial information.

11. Please indicate the number of:

Owners, Officers, Partners _____ Exclusive Non-Employee Producers _____
 Employed Solicitors, Brokers, Agents _____ Non-Exclusive Non-Employee Producers _____
 All Other Employees _____

List all agency owners, officers and licensed producers:

Name	Position/Title	License No.	No of Years Licensed	No of Years with Applicant
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

12. Office Controls and Procedures:

- a. Does the Applicant have a Home Page and/or Web Site? Yes No
 If Yes, is it used for Marketing? Yes No
 If Yes, is it used for Sales? Yes No
 Are applications completed/submitted/bound through the internet Yes No
- b. Does Applicant utilize a computerized accounting, billing and production System? Yes No
- c. Is it standard office procedure to : Yes No
 Date stamp incoming mail? Yes No
 Document all telephone conversations? Yes No
 Maintain a policy expiration list? Yes No
 Check all applications, policies and endorsements for accuracy? Yes No
 Maintain a diary/suspense system? Yes No

d. Please describe the procedures/manual documentation used to ensure the above procedures are implemented

e. Does the Applicant have a specific orientation program/office manual review for all new employees? Yes No

13. a. Has any prospective insured, or any of its employees, ever been subject to an investigation by a state regulatory agency, administrative agency and/or an insurance department investigation or inquiry or disciplinary investigation or proceeding in any way? Yes No

If Yes, please provide an explanation _____

b. Has any prospective insured, or any of its employees, ever had their license revoked. Suspended, or been fined or disciplined by any state or regulatory department? Yes No

If Yes, please provide an explanation _____

14. Has any policy or application for Errors and Omission insurance on behalf of the Applicant, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors ever been declined, cancelled or renewal refused within in the last five year (5) years? Yes No

If Yes, please provide an explanation _____

15. During the past five (5) years, has any claim or notice of claim been made or suit brought against The Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors? Yes No

If Yes, A CLAIM SUPPLEMENTAL APPLICATION MUST BE COMPLETED AND ATTACHED.

IT IS UNDERSTOOD AND AGREED THAT, WITHOUT LIMITING ANY RIGHTS OF THE UNDERWRITER, IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED INSURANCE.

Is the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors aware of any fact, circumstance, situation, allegation, contention or incident which may result in a claim being made against the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors? Yes No

If Yes, A CLAIM SUPPLEMENTAL APPLICATION MUST BE COMPLETED AND ATTACHED.

IT IS UNDERSTOOD AND AGREED THAT, WITHOUT LIMITING ANY RIGHTS OF THE UNDERWRITER, IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED INSURANCE.

16. List Errors and Omissions carriers/information for the last 3 years. (if none, state "none").
17.

	Name of Carrier	Policy Period	Limits of Liability	Deductible	Premium	Retro Date
a)	_____	_____	_____	_____	_____	_____
b)	_____	_____	_____	_____	_____	_____
c.)	_____	_____	_____	_____	_____	_____

17. a.) Limit of Liability requested.
b.) Deductible requested.

Please provide the following additional information:

1. Current annual report and company literature/promotional material.
2. Latest audited financial statements.
3. Resumes of key Principals.

Applicant hereby represents after inquiry, that information contained herein and in any supplemental applications or forms required hereby, is true, accurate and complete, and that no material facts have been suppressed or misstated. Applicant acknowledges a continuing obligation to report to the Company as soon as practicable any material changes in all such information, after signing the application and prior to issuance of the policy, and acknowledges that the Company shall have the right to withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance based upon such changes.

Further, Applicant understands and acknowledges that:

1. If a policy is issued, the Company will have relied upon, as representations, this application, any supplemental applications, and any other statements furnished to the Company in conjunction with this application, all of which are hereby incorporated by reference into this application and made a part thereof.
2. This application will be the basis of the contract and will be incorporated by references into and made part of such policy; and
3. Applicant's failure to report to its current insurance company any claim made against it during the current policy term, or act, omission or circumstances which Applicant is aware of which may give rise to a claim before the expiration of the current policy may create a lack of coverage.
4. The policy applied for provides coverage on a claims made and reported basis and will apply only to claims that are first made against the insured and reported in writing to the Company during the policy period. Claims expenses are within and reduce the limit of liability.

Applicant hereby authorizes the release of claim information to the Company from any current or prior insurer of the Applicant.

Applicant's Authorized Representative _____

Signature of Authorized Representative

Print Name of Authorized Representative

Title of Authorized Representative

Date: ____/____/____
Mo day year

Insurance Agents and Brokers Professional Liability Insurance Policy Claim Supplemental Application

Please complete ONE supplemental application for each claim or incident.

1. Name Insured: _____
2. DBA (if any): _____
3. Name(s) of Claimant(s) or potential Claimant(s) _____
4. Date of alleged act, error or omission: _____ Date of _____
5. Please indicate: Incident (potential claim) Claim Lawsuit
5. Additional defendant(s) or potential defendant(s):

7. a). Is this matter CLOSED? Yes No

If closed, total paid, including deductible(s):

Claimant's settlement demand: \$ _____ Claim Lawsuit
Insurer's reserve: \$ _____

8. Name of Insurer responding to this matter _____
 - a. Description of claim/suit: _____
 - b. Alleged act, error or omission: _____
 - c. Type and extent of injury or damage alleged to have been sustained: _____

9. Please explain what corrective action(s) have been taken to prevent recurrence of same or similar claim:

It is hereby understood and agreed this Claim Supplemental Application, and required attachment(s) becomes part of and is deemed attached to the INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABILITY INSURANCE POLICY APPLICATION.

Signature of Applicant _____ Print Name _____
Date Signed _____ Title: _____

Managing General Agent/Underwriter Supplemental Application

Note: Please attach a sample contract of engagement.

1. Name Insured: _____
- DBA (if any): _____
- Home Office Mailing Address: _____
- Physical Address: _____
- Phone: () _____ FAX: () _____ EMAIL: _____
- Additional Locations: _____
- _____

2. a). List ALL carriers for whom you are an MGA, MGU or Program Administrator:

Carrier	Line of Insurance	Number of Years	Annual Gross Written Premium	Loss Ratio Each of the Last 3 Years		
				%	%	%

- b.) Please describe any industries in which you specialize: _____
- _____

- 3.) Please describe ALL functions you perform as an MGA, MGU and/or Program Administrator.

4. List and describe the circumstances behind all insurance carriers who MGA/MGU and/or Program Administrator contracts have been terminated in the last 5 years. _____

5. Please indicate:

- a.) Number of policies issued annually: _____
- b.) Maximum limits of liability you are able to issue, by line(s) of business. _____
- c.) Number of producers from whom you accept business: _____
- d.) Number of producers/agents with binding authority: _____
- e.) Number of audits performed by carrier(s) annually: _____
- f.) Does the Applicant have a specific orientation program/office manual review for all new employees? Yes No

6. Please describe the procedures/manual documentation used to ensure the adherence to client procedures. _____

It is hereby understood and agreed this Managing General Agent/Underwriter Supplemental Application, and required attachment(s) becomes part of and is deemed attached to the INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABILITY INSURANCE POLICY APPLICATION.

Signature of Applicant _____
Print Name _____

Date Signed: _____
Title: _____

Third Party Administration and Claims Administrative Services Supplemental Application

NOTE: Please attach a sample contract of engagement.

1. Named Insured: _____

DBA (if any): _____

Home Office Mailing Address: _____

Physical Address: _____

Phone: () _____ FAX: () _____ EMAIL: _____

Additional Locations: _____

2. Description of Operations:

a). Please provide a breakdown showing the approximate percentages of the total operations:

Insurance Company Claims Adjusting	_____	%
Self Insured/RRG Claims Adjusting	_____	%
Reinsurance Claims Adjusting	_____	%
Public Adjusting	_____	%
Utilization and Reviews	_____	%
Medical Bill Review/Cost Containment	_____	%
Other: (Specify)	_____	%

b). Percentage of annual gross revenues by line of business:

COMMERCIAL LINES		PERSONAL LINES	
Commercial Liability	%	Automobile	%
Commercial Property	%	Homeowners	%
Products Liability	%	Other (Specify)	%
Automobile	%		
Workers Compensation	%	LIFE AND A&H	%
Medical Malpractice	%	Life	%
Professional Liability – (Specify)	%	HMO/PPO/DSP	%
Other (Specify)	%	Other (Specify)	%

c). Please describe ALL programs/classes and/or areas of specialization.

d). Please list your top five clients, services provided and revenues generated:

Client	Description of Services	Revenues
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does your firm:

- a). Have draft authority: Yes No
If Yes, please indicate amount. \$ _____
- b). Have its authority and/or limitations by clients defined in writing: Yes No
- c). Handle subrogation/salvage? Yes No
- d). Have a fee collection process to minimize the need to file suit to collect your fees? Yes No
- e). Provide any guarantees or warranties to your clients relative to the services provided? Yes No
- f). Have medical doctors or nurses on staff to evaluate and/or provide opinions on recommended/appropriateness of medical treatments: Yes No
- g). Does your firm have a specific orientation program/office manual review for all new employees? Yes No

4. Please describe the procedures/manual documentation used to ensure the adherence to client procedures.

It is hereby understood and agreed this Supplemental Application, and required attachment(s) becomes part of and is deemed attached to the INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABILITY INSURANCE POLICY APPLICATION.

Signature of Applicant _____
Print Title _____
Title: _____ Date Signed: _____