

LIFE INSURANCE AGENTS PROFESSIONAL LIABILITY *Application*

NOTICE: This is an application for claims made and reported insurance. Such insurance if accepted by the Company, subject to policy provisions, applies only to those claims which are the result of wrongful acts occurring subsequent to the Retroactive Date and which are first made against you and reported to us during the policy term or any applicable Extended Reporting Period. The policy provides that the limit of liability shall be reduced by the amounts paid for legal defense.

- Preferred Risk Characteristics**
- Retail agency only cannot insure Managing General Agents/Wholesalers
 - Have \$1,000,000 or less in annual commission income. *Please contact us to accommodate higher commission income.*
 - Have limited claims history

1a Applicant's Name _____ DBA (if applicable) _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (____) _____ Fax (____) _____ Email Address _____

Contact Person _____ Title _____

1b Does the applicant own 100% of the listed DBA? Yes No N/A

1c Does the applicant own any business entities not listed on the application? Yes No

1d Please list any additional insureds _____ Additional named insureds _____

2 Applicant is: Sole Proprietorship Partnership Corporation

3 Date first licensed: Life/Health* ____ / ____ / ____ Series 6 (if applicable) ____ / ____ / ____ (if applicable) ____ / ____ / ____
 *If less than three years, provide resumes for each agency principle.

4 Please check the professional designations you currently hold:
 CLU RHU LUTCF ChFC CIC REBC CPCU RPLU Other _____

5 Has the applicant been involved with any mergers, purchases or, acquisitions in the past five years? Yes No
 If yes, please describe on a separate sheet.

6 Has the applicant ever had any professional license terminated or suspended? Yes No

7 Have any professional liability claims been made against the applicant or any of its past or present owners, officers, partners, employees, or solicitors, or to the knowledge of the applicant on behalf of its predecessors in business, within the last five years?
 If yes, a Supplemental Claim form must be completed and submitted with this application. The Supplemental Claim Information Form is available on the web at www.rockwoodinsurance.com in the Life Agents E&E section. Yes No

8 Are there any known circumstances or incidents which may result in a professional liability claim? Yes No
 If yes, give details on a separate sheet.

9 Declarations of "LICENSED" persons, (including yourself), whether owners, partners, directors, officers, or employees (selling or not).

A	NAME OF LICENSED PERSON	DESIGNATIONS CODE*	COMMISSIONS	
			LAST 12 MONTHS	NEXT 12 MONTHS
			\$ _____	\$ _____
			\$ _____	\$ _____
			\$ _____	\$ _____
			\$ _____	\$ _____

B Total Number of sub-agents, brokers, and independent contractors _____ \$ _____ \$ _____

*Designation Codes: O = Owner P = Partner OF = Officer/Director
 E = Employee If necessary, use a separate sheet.

Total Commissions: \$ _____ \$ _____

C Unlicensed Staff: Total Number _____ Full Time _____ Part Time _____

1099 employees are excluded by the policy form, unless added by endorsement. Please note that the policy covers the applicant for any liability resulting from the actions of independent contractors so long as revenues from independent contractor(s) are indicated above.

10 Do you verify that all non-employed sub-agents/independent contractors are required to carry Errors and Omissions coverage? Yes No

11 Please indicate percentages of the applicants revenue derived from each line of business written below: **The total of all lines should equal 100%.**

_____ % Life-Individual _____ % A&H-Individual _____ % Stocks _____ % Variable Annuities
 _____ % Life-Group _____ % A&H-Group _____ % Bonds _____ % Equity Indexed Annuities
 _____ % Fixed Annuities _____ % Mutual Funds _____ % RIA/Financial Planning _____ % All Other (Describe on a separate sheet)
 * _____ % Pension/Employee Benefit Planning * _____ % Insurance Consulting **Please provide a brief description on a separate sheet.**

- 12a Does the applicant require coverage for Financial Products (Mutual Funds and Variable Annuities)? Yes No
If Yes, an additional premium will apply.
- 12b Does the applicant require coverage for Investment Services (Stocks, Bonds, RIA/Financial Planning)? Yes No
If Yes, an additional premium will apply.
- 12c Do you charge fees for investment services or advice? Yes No
- 12d Does the applicant require coverage for incidental Property & Casualty placements? Yes No

If Yes, what is the annual commission income derived from P&C related activity? \$ _____

NOTE: Restrictions apply. A supplemental P&C Activities Application must be completed so eligibility can be determined.

NOTE: The activities listed in questions 12a and 12b are subject to a sublimit: actions selling variable annuities, mutual funds, stocks bonds; actions as a financial planner/registered investment advisor.

13 *If Yes to 12a and/or 12b please provide:* Name of Broker Dealer _____
Name of Registered Representative(s) _____

14 Does the applicant place coverage or have involvement with Self Insured/Captives or Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), Multiple Employer Trusts (MET), Multiple Employer Welfare Arrangements (MEWA), Stop Loss Products or any self funded or partially funded product? Yes No ***If yes, please provide a brief description of activities in this area (on a separate sheet).***

15 List the top five Insurance Companies with which you place business:

Name of Insurance Company	Products Sold	% of Revenues
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %
_____	_____	_____ %

16 Do you currently have Errors and Omissions Insurance in Force? Yes No
If yes, what is: Name of Insurer _____ Expiration Date _____
Retroactive Date _____ Current Limits \$ _____ Deductible \$ _____ Premium \$ _____

Do you wish to purchase prior acts coverage? Yes No

NOTE: Prior Acts coverage may only be available if the applicant has had continuous coverage in force with no gaps. If the applicant has not carried coverage or is not able to provide proof of coverage, the retroactive date of the policy will be inception. If "Yes", proof of prior coverage will be required.

17 Limits of liability desired \$ _____ Deductible amount desired \$ _____

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY. SUCH POLICY MAY BE CANCELLED BY THE COMPANY FROM INCEPTION UPON DISCOVERY THAT THE POLICY WAS OBTAINED THROUGH FRAUDULENT STATEMENT, OMISSION, OR CONCEALMENT OF THE FACTS MATERIAL TO THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED BY THE COMPANY. THE APPLICANT REPRESENTS THAT THE STATEMENTS AND RESPONSES TO THE QUESTIONS ON THIS APPLICATION ARE ACCURATE AND COMPLETE. APPLICANT ALSO WARRANTS THAT SUCH STATEMENTS AND RESPONSES ARE TRUE, CONTAIN NO MISREPRESENTATIONS AND THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION OR ATTACHMENTS THERETO CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES.

Signature _____ Date _____
(Must be signed by an owner or officer of the applicant)

Please Print Name _____ Title _____
Referred by:
Agent Name _____ E-mail _____ Tel (_____) _____

LIFE INSURANCE AGENTS PROFESSIONAL LIABILITY

Supplemental Claim Information Form

Applicant's Instruction: This form is to be completed by the Applicant who has been involved in any claim or suit or is aware of any facts, circumstances, acts, errors, or omissions which may give rise to a professional liability claim. COMPLETE ONE FORM FOR EACH SUCH CLAIM OR CIRCUMSTANCE.

If space is insufficient to answer any question fully, attach a separate sheet. Answer ALL questions completely.

1 Full name of Applicant _____

2 Full name of individual(s) or firm involved in claim _____

3 Full name of claimant _____

4 Indicate whether: Claim/Suit or Incident 5 Date of alleged error ___/___/___ 6 Date of claim ___/___/___

7A Description of Claim: (Provide enough information to allow evaluation and use a separate exhibit if additional space is required)

7B Description of case and events _____

8 Additional Defendants _____

9 IF CLOSED

Total Loss Paid including Deductible .. \$ _____

10 IF PENDING

Claimant's Settlement Demand \$ _____ Defendant's Offer for Settlement \$ _____

Insurer's Loss Reserve \$ _____ Deductible \$ _____

Is Claim In Suit? Yes No If Yes, Amount Asked In Complaint ... \$ _____

11 Name of Insurer _____

12 Please describe procedures instituted to avoid like claims _____

I understand that the information submitted herein becomes a part of my Life Insurance Agents Professional Liability Application and is subject to the same notifications, warranties and conditions.

Applicant's Full Name _____

Signed _____ Date _____

RESUMÉ

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth ____ / ____ / ____

Position in Agency _____

INSURANCE EXPERIENCE

From ____ / ____ / ____ To ____ / ____ / ____

Employer _____

Title _____

Job Description _____

From ____ / ____ / ____ To ____ / ____ / ____

Employer _____

Title _____

Job Description _____

From ____ / ____ / ____ To ____ / ____ / ____

Employer _____

Title _____

Job Description _____

INSURANCE EDUCATION

Insurance Courses/Classes _____

Insurance Licenses/Designations _____

Date Licensed ____ / ____ / ____ Expiration Date ____ / ____ / ____