GESTIONNAIRES D'ASSURANCES
SUM
STRATEGIC UNDERWRITING MANAGERS INC

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APPLICATION – BROKERS ERRORS AND OMISSIONS
PROFESSIONAL LIABILITY INSURANCE

☐ New Application ☐ Renewal Application

If it is a renewal, provide Policy Number ______________________________ Expiration date ________________

1. FULL NAME OF THE APPLICANT (if more than one, show principal applicant **only**, and additional applicants below):

____

____

Additional applicants (to be named insureds)

Name	Activities
______________________________	____
______________________________	____
______________________________	____

2. HEAD OFFICE ADDRESS:

____

____

Date Established: ____ Month ________ Year ________

Phone: ________________________ Fax: ________________________

Website: ____

Contact Email: ____

Location(s) of Branch offices: ____

3. HAS THE NAME OF THE BROKERAGE, OWNERSHIP OR PRINCIPALS OF THE BROKERAGE CHANGED, OR HAS ANY OTHER BUSINESS BEEN PURCHASED, MERGED OR CONSOLIDATED WITH THE BROKERAGE, INCLUDING THE PURCHASE OF ANOTHER BROKER'S BUSINESS, DURING THE PAST FIVE YEARS?

☐ Yes ☐ No If "Yes" please list details below including gross income derived from other business.

____

____

____

4. IS THE BROKERAGE ENGAGED IN ANY OTHER BUSINESS? ☐ Yes ☐ No

If "Yes" please provide details:

____

____

____

5. IS THE BROKERAGE OWNED BY, ASSOCIATED WITH OR CONTROLLED BY ANY OTHER BUSINESS(ES)? ☐ Yes ☐ No

If "Yes'; please provide name, percentage of ownership, description of business of parent or controlling interest, kind and amount of insurance derived from associated businesses or owner.

____

____

____

6. A) TOTAL GROSS P&C PREMIUMS WRITTEN ANNUALLY $________________

B) TOTAL LIFE, ACCIDENT & HEALTH COMMISSIONS WRITTEN ANNUALLY $________________

7. WHAT PERCENTAGE OF TOTAL INCOME COMES FROM:

Insurance __________%

Claim Settlement for a fee __________%

Premium Financing

For own clients __________%

For others __________%

Consulting for a fee __________%

Third Party Administration for

Employee Benefit / Pension Plan __________%

Other (Specify) __________%

(MUST TOTAL 100%)

8. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL PREMIUM VOLUME.

Business placed as:

______% Broker (with binding authority) ______% MGA* (with binding authority)

______% Broker (without binding authority). ______% MGA* (without binding authority)

100% TOTAL

*(MGA / Managing General Agency: agency operating with a broad grant of authority by an insurance company or Lloyd's to underwrite, bind and issue policies.)

9. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL PREMIUM VOLUME:

Business received or assumed:

______% Direct from insureds

______% From other brokers

100% TOTAL

10. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL P&C PREMIUM VOLUME.

______% Personal Lines

______% Commercial Lines

100% TOTAL

11. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL P&C PREMIUM VOLUME:

Classes of Business:

Animal mortality ______%

Automobile:

Long Haul Trucking ______%
(50 miles radius and greater)
Commercial (All other) ______%
Personal ______%

Aviation ______%

Bonds:

Surety / contract ______%
Other bonds ______%

Crop Insurance ______%

General Property / Casualty ______%

Inland Marine ______%

Professional Liability ______%

Wet Marine:

Commercial ______%
Pleasure ______%

Other (Specify) ______%

TOTAL 100%

12. IS THE BROKERAGE ASSOCIATED WITH A CLUSTER OR SIMILAR TYPE ARRANGEMENT?

☐ Yes ☐ No If "Yes", please provide details.

13. DOES ANYONE FROM THE BROKERAGE SIT ON ANY COMPANY BOARD OF DIRECTORS OR GOVERNING COMMITTEES INVOLVING AN INSURANCE RELATED ACTIVITY?

☐ Yes ☐ No If "Yes", please provide details.

14. PLEASE LIST THE INSURANCE COMPANIES WHICH TOGETHER ACCOUNT FOR 100% OF YOUR TOTAL PREMIUM VOLUME AND INDICATE IF YOU HAVE BINDING AUTHORITY. PLEASE INCLUDE ALL INSURERS USED VIA AN INTERMEDIARY.

(It is not sufficient to show just the name of the intermediary)

COMPANY	%	BINDING? YES/NO	DO YOU HAVE DIRECT ACCESS? (YES/NO) (If No, give name of intermediary)

15. PLEASE LIST ANY UNLICENSED OR NON-ADMITTED INSURANCE COMPANIES THAT YOU PLACE BUSINESS WITH.

COMPANY	%	BINDING? YES/NO	DO YOU HAVE DIRECT ACCESS? (YES/NO) (If No, give name of intermediary)

16. PLEASE INDICATE THE BROKER'S E&O CARRIER FOR THE LAST THREE YEARS. If none, state none.

CARRIER	POLICY NUMBER	LIMIT	EFFECTIVE AND EXPIRATION DATE	CURRENT PREMIUM (OPTIONAL)
		$		$
		$		$
		$		$
		$		$

17. IF YOU HAVE NOT HAD ERRORS AND OMISSIONS COVERAGE FOR THE LAST (3) YEARS OR HAVE HAD A GAP IN COVERAGE, PLEASE GIVE US A NARRATIVE EXPLANATION.

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18. PLEASE GIVE INFORMATION REQUESTED FOR ALL BROKER STAFF. Over 20 hours is counted as full time.

	NAME	LICENSED? YES/NO	PROFESSIONAL DESIGNATION	POSITION	FULL TIME OR PART TIME?
a) Licensed Owners, Partners, Officers, Directors:					
b) Licensed producers who are employees of the brokerage:					
c) All other employees including non licensed owners, partners, officers and directors:					
SUB-TOTAL OF FULL AND PART - TIME EMPLOYEES (a + b + c) ________________________________					
d) Operational Coverage producers, office brokers who are not employees of the Brokerage and are to be named as Additional Insureds					
SUB-TOTAL TO BE NAMED AS ADDITIONAL INSUREDS (18. d) ________________________________					

e) If more than one office, please indicate the total number of staff members at each location.
Location # 1__________ # 2__________ # 3__________ (Total of all to be included above and below.)
If more locations, attach sheet with information on staff members at each location.
TOTAL STAFF ________________________

f) Do any of the persons listed in a) to e) above work for any other brokerage or for themselves? ☐ Yes ☐ No
If Yes, please provide details.

____
____
____

19. DID ANY OF YOUR EMPLOYEES PARTICIPATE IN AN ERRORS AND OMISSIONS PREVENTION SEMINAR DURING THE PAST 24 MONTHS? ☐ Yes ☐ No

If "Yes", please provide details including date, number of staff, and sponsor of program.

____
____
____

20. PLEASE DESCRIBE THE DETAILS OF TRAINING SESSIONS OR COURSES PROVIDED OR TAKEN:

____
____
____

21. PLEASE DESCRIBE YOUR ORIENTATION PROGRAM FOR NEW EMPLOYEES:

____
____
____

22. IS ALL INCOMING MAIL DATE STAMPED? ☐ Yes ☐ No

23. ARE VERBAL BINDERS CONFIRMED IN WRITING? ☐ Yes ☐ No

24. ARE COPIES OF BINDERS MAILED TO BOTH INSURED AND INSURANCE CARRIER WITHIN THREE (3) DAYS? ☐ Yes ☐ No

25. IS THERE A PROCEDURE FOR DOCUMENTING IMPORTANT PHONE CONVERSATIONS? ☐ Yes ☐ No

26. IS A POLICY EXPIRATION LIST MAINTAINED? ☐ Yes ☐ No

27. ARE ALL POLICIES AND ENDORSEMENTS CHECKED FOR ACCURACY BEFORE MAILING? ☐ Yes ☐ No

28. PLEASE DESCRIBE THE LEVELS OF AUTOMATION WITHIN YOUR BROKERAGE:

____

____

____

29. DOES THE APPLICANT HAVE A PLANNED DIARY, SUSPENSE OR FOLLOW-UP SYSTEM?

☐ Yes ☐ No If "Yes': please describe.

____

____

____

30. DOES THE APPLICANT HAVE A FORMAL TRAINING/COMPLIANCE MANUAL ALONG WITH A DESIGNATED PERSON RESPONSIBLE FOR THE MAINTENANCE OF THE MANUAL?

☐ Yes ☐ No If No, please comment.

____

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____

31. DOES THE APPLICANT HAVE A WRITTEN PROCEDURE THAT HAS BEEN COMMUNICATED TO ALL PERSONS ENGAGED BY THE APPLICANT THAT DETAILS THE PROCEDURE FOR THE HANDLING OF COMPLAINTS AND/OR THE NOTIFICATION OF CIRCUMSTANCES AND/OR CLAIMS TO PROFESSIONAL INDEMNITY INSURERS?

☐ Yes ☐ No If Yes, who is the person responsible. If No, please comment.

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____

32. DOES THE APPLICANT HAVE A DOCUMENTED FILE REVIEW PROCEDURE FOR RISKS WHICH IN THE OPINION OF THE APPLICANT ARE HIGH RISK OR NON-STANDARD ACCOUNTS?

☐ Yes ☐ No If No, please comment.

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33. DOES THE APPLICANT RETAIN ON EACH FILE SUFFICIENT INFORMATION TO RECORD ON EACH FILE WHY A CERTAIN INSURANCE POLICY OR TRANSACTION WAS RECOMMENDED AS BEING SUITABLE FOR CLIENT'S REQUIREMENTS? ☐ Yes ☐ No If No, please comment.

34. IS A SUMMARY LETTER STATING THE REASONS WHY A CERTAIN POLICY/TRANSACTION WAS RECOMMENDED SENT TO CLIENTS AS A MATTER OF COURSE FOR ALL ACCOUNTS?
☐ Yes ☐ No If No, please comment.

35. DOES THE APPLICANT HAVE A FORMAL DISASTER RECOVERY PLAN?
☐ Yes ☐ No If No, please comment.

36. DOES THE APPLICANT RETAIN DAILY OFF-SITE BACKUPS FOR ALL ELECTRONIC DATA?
☐ Yes ☐ No If No, please comment.

37. IF THE APPLICANT HAS NOTIFIED CLAIMS OR CIRCUMSTANCES TO INSURERS WHAT ACTION HAS THE APPLICANT TAKEN TO REVIEW AND IMPROVE INTERNAL PROCEDURES FOLLOWING THE NOTIFICATIONS TO INSURERS? PLEASE DESCRIBE AND/OR COMMENT.

38. DOES THE APPLICANT USE INSURERS NOT RATED BY BEST'S OR RATED BELOW "B"?
☐ Yes ☐ No If Yes, please comment.

39. IF THE ANSWER TO QUESTION 38 IS YES, DOES THE APPLICANT WARN CLIENTS ABOUT UN-RATED OR BELOW "B" RATED SECURITY? ☐ Yes ☐ No If No, please comment.

____

____

____

40. IF THE ANSWER TO QUESTION 38 IS YES, DOES THE APPLICANT VET THE SECURITY?
☐ Yes ☐ No If No, please comment.

____

____

____

41. DO YOU PLACE ANY RISKS (DIRECTLY OR THROUGH AN INTERMEDIARY OR WHOLESALER) WITH UNLICENSED INSURERS? ☐ Yes ☐ No

42. WHAT STEPS DO YOU TAKE TO CHECK THE FINANCIAL STRENGTH OF INSURERS YOU USE (DIRECTLY OR THROUGH AN INTERMEDIARY OR WHOLESALER)?

____

____

____

43. DOES THE APPLICANT CURRENTLY CARRY PROFESSIONAL OR ERRORS AND OMISSIONS LIABILITY INSURANCE? ☐ Yes ☐ No

i) If Yes, please indicate the name of the Insurer: ______________________________

____

ii) Please indicate if such coverage is offered on an occurrence basis or claims made basis
☐ Occurrence ☐ Claims Made

iii) If current coverage is on a claims made basis, what is the retroactive date? ____________________

iv) What is your current policy limit? $________________

v) What is your current deductible? $________________

vi) If you are presently insured, are renewal terms being offered? ☐ Yes ☐ No

vii) If No, please state reason: ______________________________

____

44. A) HAVE ANY CLAIMS EVER BEEN MADE TO THE KNOWLEDGE OF THE APPLICANT AGAINST THE APPLICANT, ANY BUSINESS PREDECESSORS, OR ANY OF THE PRESENT OR FORMER PARTNERS OR OFFICERS? ☐ Yes ☐ No

B) IS THE APPLICANT AWARE OF ANY ACT, ERROR, OMISSION OR CIRCUMSTANCES WHICH COULD GIVE RISE TO A CLAIM AGAINST THE APPLICANT OR ANY PREDECESSOR IN BUSINESS, OR ANY PRESENT OR FORMER PARTNER OR OFFICER? ☐ Yes ☐ No

IF THE ANSWER TO EITHER Q.44 a) OR Q.44 b) IS YES, COMPLETE THE ENCLOSED CLAIMS HISTORY FORM

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 44 a) AND/OR 44 b) OR ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

45. HAS ANY PARTNER, EXECUTIVE OFFICER, DIRECTOR OR PROFESSIONAL EMPLOYEE HAD THEIR LICENCE SUSPENDED, BEEN FINED OR REPRIMANDED DURING THE PAST FIVE YEARS?

☐ Yes ☐ No If Yes, attach details.

46. TO THE APPLICANT'S KNOWLEDGE, HAS ANY COMPANY DECLINED OR TERMINATED THE INSURANCE FOR THE APPLICANT, ANY PRESENT PARTNER OF OFFICER OR FOR ANY PREDECESSOR IN THE BUSINESS, PAST PARTNERS OR OFFICERS? ☐ Yes ☐ No

If Yes, provide details:

____

____

47. PLEASE NOTE THE PROFESSIONAL ASSOCIATIONS TO WHICH THE APPLICANT BELONGS:

____

____

48. WHEN IS YOUR FISCAL YEAR END? ______________________________

49. INSURANCE REQUIRED:

LIMITS:	DEDUCTIBLES:
☐ $ 500,000 / 1,000,000	☐ $ 2,500
☐ $ 1,000,000 / 1,000,000	☐ $ 5,000
☐ $ 1,000,000 / 2,000,000	☐ $ 10,000
☐ $ 2,000,000 / 2,000,000	☐ $ 25,000
☐ $ 5,000,000 / 5,000,000	
☐ Other ____________________	☐ Loss Only
	☐ Loss and Litigation Expense

We hereby declare that the above statements and particulars are true and that we have not suppressed or misstated any material facts and we agree that this declaration shall be the basis of any binder or contract of insurance with the Insurance Company, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this application does not bind the Insurance Company to the issue of the insurance nor the Applicant to the purchase of this insurance.

It is further understood and agreed that if, following submission of this application to the Insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 44 a) or 44 b) of this application, the Insurer shall be immediately notified in writing of such information.

Signature of Applicant: ______________________________ Dated: ____________________

Print Name and Title: ______________________________

Firm Name: ______________________________

BROKER NAME: ______________________________

ADDRESS: ______________________________

____

____

PHONE NO: ______________________________

FAX NO: ______________________________

EMAIL ADDRESS: ______________________________

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CLAIMS HISTORY FORM

Applicant Name: ______________________________ Date: ____________________

Claimant Name: ______________________________
Claimant's Insurer: ______________________________
Policy Number: ______________________________
Type of Cover: ______________________________
Date of Claim: ______________________________
Description of Claim: ______________________________
____
____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
ESTIMATED LIABILITY	$
INDEMITY PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________
Claimant's Insurer: ______________________________
Policy Number: ______________________________
Type of Cover: ______________________________
Date of Claim: ______________________________
Description of Claim: ______________________________
____
____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
ESTIMATED LIABILITY	$
INDEMITY PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________
Claimant's Insurer: ______________________________
Policy Number: ______________________________
Type of Cover: ______________________________
Date of Claim: ______________________________
Description of Claim: ______________________________
____
____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
ESTIMATED LIABILITY	$
INDEMITY PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________
Claimant's Insurer: ______________________________
Policy Number: ______________________________
Type of Cover: ______________________________
Date of Claim: ______________________________
Description of Claim: ______________________________
____
____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
ESTIMATED LIABILITY	$
INDEMITY PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________
Claimant's Insurer: ______________________________
Policy Number: ______________________________
Type of Cover: ______________________________
Date of Claim: ______________________________
Description of Claim: ______________________________
____
____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
ESTIMATED LIABILITY	$
INDEMITY PAID	$
EXPENSES PAID	$