

## APPLICATION FOR A CLAIMS MADE AND REPORTED LAWYERS PROFESSIONAL LIABILITY POLICY

**PLEASE TYPE OR PRINT IN INK AND RETURN WITH A SAMPLE OF YOUR LETTERHEAD**

Firm/Applicant Name	Business Phone with Area Code	Email Address
Principal Business Address	Business Fax with Area Code	Effective Date Requested
City      County      State      Zip		

1. Please list all attorneys practicing on behalf of your firm. Add an attachment if necessary.

Attorney Name	Social Security Number	Years in Private Practice	Designation Code (See Choices Below)	Current Legal Malpractice Insurance Carrier	Current Retroactive Date

**Designation Code:** E = Member/Employee of the Firm, OC = Of Counsel/Independent Contractor and F = Full Time, P = Part Time (26 hours or fewer per week)

2. Have any members of your firm been reprimanded, censured, suspended or disbarred within the past five (5) years? If YES, provide full details on your letterhead.       Yes     No
  
3. Have any Professional Liability Claim(s) or suit(s) been made against the applicant firm or any attorney(s) in the applicant firm or former attorney(s) in the applicant firm within the past five (5) years? If YES, complete the Claim Supplemental Application.       Yes     No
  
4. After inquiry, are you or any attorney in your firm aware of any circumstances, incidents, acts or omissions that have led to a Professional Liability Claim that has not yet settled or which could lead to a Professional Liability Claim being made against your firm? If YES, complete the Claim Supplemental Application       Yes     No
  
5. Please list the limit of liability and deductible currently carried and select the appropriate type of limit and deductible. Select the limit and deductible requested.

CURRENT			DESIRED		
Limit: \$ _____			Limit: \$ _____		
<input type="checkbox"/> Defense Costs Part of the Limit <input type="checkbox"/> Defense Costs Outside the Limit <input type="checkbox"/> Don't Know			<input type="checkbox"/> Defense Costs Part of the Limit <input type="checkbox"/> Defense Costs Outside the Limit <input type="checkbox"/> Don't Know		
Deductible: \$ _____			Deductible: \$ _____		
Per Claim	Aggregate	Loss Only	Per Claim	Aggregate	Loss Only
Premium: \$ _____					

6. Please provide the percentage of gross billable dollars allocated to each Area of Practice. Please round to the nearest whole number. Total must equal 100%.

Admiralty/Maritime		Government-Federal and State	
Antitrust		Government-Local (Not Bond Work)	
Business Transactions-Corporate & Commercial		Immigration/Naturalization	
<b>BUSINESS TRANSACTIONS-ENTERTAINMENT</b>		International Law	
Civil Rights/Discrimination		Labor Law	
Collection/Bankruptcy		PI/PD-Plaintiff	
Construction Law (Building Contracts)		Insurance Defense	
Consumer Claims		Workers' Compensation-Defense	
<b>BUSINESS ORGANIZATION:</b>		Workers' Compensation-Plaintiff	
Formation/Alteration and Mergers/Acquisitions		Natural Resources/Oil & Gas	
Secured Transactions		Patents/Trademarks/Copyrights (Intellectual Property)	
Administrative Law/Record Keeping		Real Estate	
Criminal		<b>SECURITIES LAW</b>	
Environmental Law		State or Federal (both exempt and registered)	
Estate/Trust/Probate		Municipal Bonds	
Family Law		Taxation/Tax Opinions	

**USE OF BOLD IN THE ABOVE TABLE INDICATES THAT A SEPARATE SUPPLEMENTAL APPLICATION IS REQUIRED.**

The applicant represents that the above statements are true and correct to the best of his or her knowledge and that no material or relevant facts have been suppressed or misstated and agree that the policy, if issued, will be issued on the reliance of such representations.

Applicant acknowledges a continuing obligation to report to us as soon as practicable any material changes in the facts or statements above, and in each supplementary application, which applicant becomes aware after signing the application.

**NOTICE TO APPLICANTS: Any person who knowingly and with the 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.**

Completion of this form does not bind coverage. Applicant's acceptance of Company's quotation is required prior to binding coverage and policy issuance. It is agreed that this application shall be the basis of the contract of insurance should a policy be issued and it will be attached to the policy.

Signature of Owner/Partner \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_