

SPECIALTY E&O PLAN

APPLICATION FOR SPECIALTY ERRORS AND OMISSIONS LIABILITY INSURANCE PLAN

Underwriting Manager: MEDIA/PROFESSIONAL INSURANCE
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WHAT YOU SHOULD KNOW ABOUT THIS APPLICATION:

— CLAIMS MADE POLICY

This application is for a CLAIMS MADE POLICY. CLAIMS MADE coverage applies only to those claims that are first made during the policy period and result from wrongful acts committed AFTER the RETROACTIVE DATE stated in the policy, if issued.

— DEFINITIONS

The words **We**, **Us** and **Our** whenever used in this application refer to the Insurance Company offering the claims made policy.

The words **You** and **Your** in this application refer individually and collectively to:

1. The corporation(s), partnership(s) and/or sole proprietorship(s) for which coverage is desired;
2. Each person who is an officer, director, owner, partner or employee of the firms listed in Item 1 above.

— DEDUCTIBLE

The coverage **You** are applying for includes a deductible applying to each wrongful act and applies to any combination of damages and claim expenses.

— CLAIM EXPENSES WITHIN LIMIT

The Policy form for which **You** are applying contains a provision that reduces the total limit of insurance stated in the policy by the amount of claim expenses paid by **Us**.

— APPLICATION FORMS PART OF POLICY

Your submission of this application does not obligate **You** to buy insurance nor are **We** obligated to sell insurance or to offer insurance upon any specific terms requested. If coverage is effected, this application containing **Your** statements and answers will attach to and form a part of the policy. If coverage is offered or bound, any false or incorrect statements or answers which may have affected **Our** decision to offer or bind coverage could result in the offer being retracted or coverage being voided.

APPLICATION FOR SPECIALTY ERRORS AND OMISSIONS LIABILITY INSURANCE POLICY

INSTRUCTIONS:

The purpose of this application is not only to provide **Us** with underwriting and rating information, but more importantly, to help make certain **You** and **We** have a meeting of minds about what the policy, if issued, will cover and what it will not. Thank **You** for taking the time to provide **Us** with accurate information.

1. Answer all questions. If any question does not apply, explain why not.
2. If space is insufficient, continue answers on **Your** letterhead.
3. The application must be signed and dated by a principal, partner, officer or director of the firm.
4. Attach:
 - A. A recent brochure or similar materials describing activities or services;
 - B. **Your** most recent financial statement or annual report.
 - C. Copies of standard contracts **You** enter into with clients; and
 - D. Any other forms or materials which will provide the underwriter with information about the services **You** perform.

PROPOSED INSURED (APPLICANT):

1. _____
 Name of **Your** firm:

 Street Address

 City, State, Zip Code Telephone No.

2. A. Provide the date **Your** firm was established. _____
- B. Geographic area in which **You** provide service(s)
 - Local • Regional (Multi State) • National • International
3. Are you owned by, or affiliated with other companies, or do you have any subsidiaries? • Yes • No
 - A. If yes, advise who they are.
 - B. For which of these do you wish to extend coverage.
4. A. Within the past five years, have **You** changed **Your** name, acquired any business, or have **You** merged or consolidated with any entity? • Yes • No

If yes, provide the following information (if more space is needed, advise by attachment)

Name of Entity	Date of Transaction	Type of Transaction (acquisition, merger or consolidation)
_____	_____	_____
_____	_____	_____

- B. In any of the transactions listed in 4. A. above, did **You** assume the liabilities (i.e. responsibility for prior acts) of the acquired, merged or consolidated entity? • Yes • No
If yes, provide details of the liability(ies) assumed.

5. A. Provide the number of **Your**:

principals, partners or officers _____
technical personnel _____
clerical personnel _____

- B. List the qualifications of key personnel or attach experience resumes of each.

- C. List professional societies and trade associations relating to the services to be insured in which **You** or any of **Your** officers are a member.

- D. Do **You** have any certified or licensed professionals on staff? (i.e. architect, engineer, medical practitioner, attorney, CPA, actuary, or insurance agent or broker, etc.)
• Yes • No If yes, what services are they providing.

OPERATIONS:

6. A. Describe the services you provide that **You** wish to insure. (Attach company brochures, advertising materials, etc. that describe these services.)

- B. Do **You** use independent contractors or subcontractors for the services described in A. above?
• Yes • No If yes, describe the services they provide and the estimated percentage of time used.

7. Briefly describe **Your** five largest jobs or projects during the past five years.

	<u>Client</u>	<u>Revenue</u>	<u>Service(s) Performed</u>
1.			
2.			
3.			
4.			
5.			

8. A. What do **You** see as **Your** potential exposure to E&O claims?

B. What safeguards or procedures do **You** employ to avoid these claims or reduce these exposures?

9. A. Do **You** use a written contract or agreement describing the services **You** will provide? • Yes • No

If yes, attach representative contracts, work orders, license agreements or letters of agreements **You** use with **Your** clients. If no, explain how you reach agreement with **Your** clients regarding the services to be insured.

B. Percentage of time agreements in 9. A. above are used _____%

C. Do your contracts contain the following:

- | | |
|--|------------|
| Hold Harmless or Indemnity Agreement inuring to Your benefit | • Yes • No |
| Hold Harmless or Indemnity Agreement inuring to Your client's benefit | • Yes • No |
| Guarantees or Warranties | • Yes • No |
| Disclaimer inuring to Your benefit | • Yes • No |

D. Has a law firm experienced in **Your** field reviewed **Your**:

- | | |
|------------|------------|
| Contracts | • Yes • No |
| Procedures | • Yes • No |

10. Provide the following information regarding **Your** income:

	Past 12 Months	Current 12 Months	Estimate for Coming Year
Domestic Operations			
Gross billings, sales, fees commissions (circle the applicable basis)	\$ _____	\$ _____	\$ _____
Foreign Operations			
Gross billings, sales, fees commissions (circle the applicable basis)	\$ _____	\$ _____	\$ _____

CLAIM EXPERIENCE:

11. A. Have any claims, suits or proceedings been made during the past five years against any of **You** or any of **Your** predecessors in business, subsidiaries or affiliates or against any of their past or present partners, owners, officers, sales persons or employees? • Yes • No If yes, complete a supplemental claim information form for each.

The policy for which You are applying, if issued, will not insure any claims, suits or proceedings made against any of You before the inception date of the policy or any subsequent claims, suits or proceedings arising therefrom.

- B. Are any of **You** aware of any actual or alleged fact, circumstance, situation, error or omission which may reasonably be expected to result in a claim being made against **You** or any of the persons or entities described in 11. A. above? • Yes • No If yes, explain below or in an attachment.

The policy for which You are applying, if issued, will not insure any claims that can reasonably be expected to arise from any actual or alleged fact, circumstance, situation, error or omission known to any of You before the inception date of the policy.

12. Have any of **You** or any of **Your** predecessors in business, subsidiaries or affiliates or any of their past or present partners, owners, officers, sales persons or employees been investigated and/or cited by any regulatory agency for violations arising out of **Your** or their activities? • Yes • No If yes, explain below or attach a statement giving details.

PRIOR OR CURRENT COVERAGE:

13. A. Provide the following information for similar insurance, if any, carried during the last five years

Company	Limit	Deductible	Premium	Policy Term
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- B. Advise current retroactive date (if claims made) _____

14. Provide the following information for **General Liability** coverage currently in force:

Company	Limit	Deductible	Policy Term
_____	\$ _____	\$ _____	\$ _____

Does the policy above include coverage for Products/Completed Operations Hazards? • Yes • No

15. Limit of Liability desired: _____ Deductible: _____

REPRESENTATIONS:

By signing this application, You agree that:

- A. The statements and answers given in this application and any attachments to it are accurate and complete;
- B. The statements and answers **You** furnish to **Us** are representations **You** make to **Us** on behalf of all persons and entities proposed for coverage;
- C. Those representations are a material inducement to **Us** to provide a proposal for insurance;
- D. Any policy **We** issue will be issued in reliance upon those representations;
- E. **You** will report to **Us** immediately, in writing, any material change in **Your** operations, condition or answers provided in this application that occur or are discovered between the date of this application and the effective date of any policy, if issued; and
- F. **We** reserve the right, upon receipt of any such notice, to modify or withdraw any proposal for insurance **We** have offered.

WARNING

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 IN NEW YORK SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Date

Your Signature

Your Title

To Be Completed by Producer(s) Only:

<u>RETAIL PRODUCER</u>	
PRODUCER NAME:	GALES CREEK INSURANCE SERVICES, INC.
CITY, STATE:	AT UNION STATION
TELEPHONE NUMBER:	800 NW 6TH SUITE 335
	PORTLAND, OR 97209
<u>WHOLESALE PRODUCER</u>	PH: (503) 227-0491 FAX: (503) 227-0927
<u>PRODUCER NAME:</u>	
<u>CITY, STATE:</u>	
<u>TELEPHONE NUMBER:</u>	

Note: Agent/broker is responsible for collection and filing of any surplus lines taxes and fees that may apply.