NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

INSURANCE AGENTS AND BROKERS ERRORS & OMISSIONS APPLICATION

APPLICANT'S INFORMATION

1. Legal name of the business who is the primary applicant and will be the first named insured listed on the policy: _____
2. Please list all other business/dba names for which you are seeking coverage under this policy: _____
3. ☐ Corporation ☐ Individual ☐ Partnership ☐ Municipality ☐ For Profit ☐ Joint Venture ☐ Other: _____
4. Please list any names of other entities that you own or manage or that you do business under (such entities are not requesting coverage under this policy): _____
5. Primary location address: _____
6. County of primary location: _____ Date business originally established: _____
7. Total number of branches? _____ List all addresses for additional branches: _____
8. What is your web-site address? www._____
9. What is your phone number? _____
10. Has the name or ownership of the entity changed or has any other business been purchased, merged or consolidated with the entity within the last 5 years? Yes ☐ No ☐
11. Does any entity own or control your business or does your business own or control any entity? Yes ☐ No ☐
12. During the past five years, has your name been changed or has any other business purchased, merged or consolidated with you? Yes ☐ No ☐

    For questions 9-11, please fully explain any "yes" response, including the names, dates, and revenue impact involved: _____
13. Please list any associations of which you are a member: _____

GENERAL INFORMATION

1. Is the agency a cluster "member" or cluster "hub"? ☐ Member ☐ Hub ☐ N/A (If N/A, proceed to question # 2.)
   a) If a "member", please explain the lines of business: _____
   b) If a "hub," how many members comprise the cluster? _____
   c) Do they carry their own E&O insurance? Yes ☐ No ☐
   d) **If "yes", do the members name the hub as an additional insured on their E&O Insurance policies?** Yes ☐ No ☐
   e) Whether a "member" or "hub", please explain the services performed by the cluster hub for or on behalf of the cluster members: _____
2. List all the Applicant firm's personnel:
   (Each individual should be classified in only one category.)

Owners, Officers, Partner	☐	Exclusive Non-employee Producers	☐
Employee Solicitors, Brokers, Agents	☐	Non-exclusive Producers	☐
Other employees (including clerical)	☐	**TOTAL STAFF** (including part time)	☐

3. List all firm's owners, officers and licensed employee producers.

Name	Position/Title	Professional Designations	# of Years Licensed	# of Years w/Applicant

4. Please provide your agency's annual premium volume, commission income, policy count, and revenue generated from "other" income not including commission income (projections only if a start-up):

	Annual Premiums	Annual Commission Income	Policy Count	Annual "Other" Income
Most recent 12 months				
Previous 12 months				
Projected next 12 months				

5. List the 5 insurance companies for whom applicant firm places the most annual premium.

Name of Insurance Company	% of Total Premium Volume	A.M. Best Rating	Years Represented	Major Lines Placed	Binding Authority? Yes or No?	If binding authority, what line of business?

6. What percent of your agency's premium volume is placed with carriers having an A.M. Best rating of B or below, or who are unrated? _____%
   a. List all insurance companies and volume of business you placed with companies having an A.M. Best rating of B or below, or with companies not currently rated:

Companies	Volume
_____	$_____
_____	$_____
_____	$_____

7. Do you have claim handling authority on behalf of any carrier? Yes ☐ No ☐

   If "yes", please provide the name of the carrier, line of business, and the dollar value of the claim authority for each company: _____

8. Approximate percentage of the total annual volume you do as:

1. Agent	____%	2. Retailer or Business direct from other agents	____%
Broker	____%	Wholesale or Business accepted from other agents	____%
Managing General	____%	**Must Total**	**100%**
Surplus Lines Broker	____%		
Consultant (for fee)	____%		
Other (specify)	____%		
Must Total	**100%**		

9. Please categorize your total **annual premium volume** by line of business:

A		C	
%	Personal Lines Home/Auto-Standard	%	Accident, Life & Health-Group
%	Subtotal (A)	%	Accident, Life & Health-Individual
B		%	Aviation
%	Auto-Commercial (except long haul trucking)	%	Crop
%	Bonds	%	Long Haul or Intermediate Trucking
%	Commercial-General Liability	%	Marine-Ocean or other "wet" marine
%	Commercial-Property	%	Physicians/Hospitals
%	Marine-Inland	%	Professional Liability/D&O
%	Personal Lines Home/Auto-Sub-Standard	%	Other (explain)
%	Workers Compensation		
%	Subtotal (B)	%	Subtotal (C)
		100%	Total A + B + C

RISK MANAGEMENT

1. Is incoming mail date stamped? Yes ☐ No ☐
   If "no", please explain why not: _____
2. Are verbal binders given? Yes ☐ No ☐
   If "yes", how and when are verbal binders confirmed in writing with the insured and insurer? _____
3. Is there a procedure for documenting telephone conversations? Yes ☐ No ☐
4. Are all application, policies and endorsements checked for accuracy? Yes ☐ No ☐
5. Are files marked to ensure certificate holders, regulatory agencies, etc., are notified of cancellation or material changes? Yes ☐ No ☐
6. Do you confirm to the Insured, in writing, all declinations of coverage? Yes ☐ No ☐
7. Do you confirm, in writing, an insured's rejection of increased uninsured motorist or underinsured motorist limits 100% of the time? **If "no", why not?** _____ Yes ☐ No ☐
8. Is applicant involved in handling any stranger-originated life insurance policies? Yes ☐ No ☐
   If "yes", please give the percentage of stranger-originated policies handled. _____ **%**
9. How do you monitor the solvency and financial condition of the insurers with which you place business and give notice to everyone in the agency of possible insurer financial trouble? _____
10. In the past 3 years, has any carrier (or other risk bearing entity) with which your agency has placed business become insolvent, bankrupt, put into rehabilitation/receivership, or otherwise become unable to meet its duties to insureds? Yes ☐ No ☐
    If "yes", please explain including the name of the entity, dates involved, lines of business placed, and premium volume involved: _____
11. Has any contract for this agency been withdrawn by a carrier in the last 3 years for any reason other than lack of production? Yes ☐ No ☐
    If "yes", please explain: _____

MANAGING GENERAL AGENTS, UNDERWRITING MANAGERS AND PROGRAM ADMINISTRATORS

12. Does the Applicant act as Managing General Agent ("MGA"), Underwriting Manager and/or Program Administrator? Yes ☐ No ☐

If Yes, answer the following questions:

13. Provide the following information for each organization that the Applicant has represented as an MGA, Underwriting Manager or Program Administrator for the last five years.

Insurer	Domicile of Insurer	Number of Years Represented	Annual Premium Volume	Number of Times Audited per Year

14. In the last three years has any audit by an insurer stated that the Applicant:
    (a) Had exceeded its premium cap or underwriting authority? Yes ☐ No ☐
    (b) Did not issue the correct policy wording and/or endorsements as mandated by the insurer? Yes ☐ No ☐
    (c) **If Yes to either of the above questions, provide details and actions taken to amend procedures.**

15. In the last three years, other than minor infractions, were all audits by insurers satisfactory? Yes ☐ No ☐
    If No, provide details. _____

16. In the last five years has any:
    (a) MGA, Underwriting Manager or Program Administrator contract authority been canceled, revoked or terminated? Yes ☐ No ☐
    (b) Insurer added any restrictions to the Applicant's underwriting or claim handling authority? Yes ☐ No ☐
    (c) **If Yes to either of the above questions, provide details.** _____

17. (a) What is the Applicant's maximum authority for the following:

    Binding Risks $_____
    Claims Adjusting/Administration $_____
    Loss Control $_____
    Reinsurance Placement $_____

    (b) Does the Applicant have authority for any insurer other than stated in IV.2. herein above? Yes ☐ No ☐
    If Yes, provide details. _____

    (c) Total number of insurers for which the Applicant has authority of any kind: _____

18. (a) Provide the total number of producers that the Applicant has appointed as sub agents. _____
    (b) Has the Applicant delegated any underwriting, claim handling and/or any other authority to any sub agent? Yes ☐ No ☐
    If Yes:
    (i) Provide a detailed description. _____

    (ii) Provide a copy of the contract with the insurer that authorizes the Applicant to delegate authority to other organizations.

INSURANCE AND LOSS HISTORY

1. Provide your agency's recent insurance history below.

	Insurance Company	Limits Per Claim/Aggregate	Policy Period (Month/Day/Year)	Annual Premium
Current Year				
Previous Year 1				
Previous Year 2				
Previous Year 3				
Previous Year 4				

2. If you are currently insured for errors & omissions coverage, what is your policy's retroactive/prior acts date? (month/day/year) _____/_____/_____ If there is no retroactive date please check here. ☐

   If requesting prior acts coverage you will be asked upon binding coverage to provide a copy of your current insurance declaration page documenting the expiring retroactive date and limits. Prior acts coverage may not be available if the date of your current retroactive coverage is different from what we have quoted or if there is any gap between effective dates.

3. Are you being canceled or non-renewed by your current professional liability carrier? ☐ Yes ☐ No
   If yes, please explain why: _____

4. Requested limits: ☐ $100k/$300k ☐ $250k/250k ☐ $500k/$500k ☐ $1m/$1m ☐ $2m/$2m
   ☐ (other) _____

   Requested deductible: ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ Other $_____

5. After inquiry with each person as appropriate, in the last five (5) years, have any claims been made against the person or entity applying for insurance, or any of your past or present partners, officers, directors, solicitors, office brokers or employees, any predecessors in business or against any corporation that any proposed Insured was formerly employed by, associated with or had an interest in? Yes ☐ No ☐
   If "yes", please complete a separate Supplemental Claim form for each claim or suit and include a currently valued loss run for each claim.

6. After inquiry with each person as appropriate, are you, or any of your partners, officers, directors, solicitors, agents, brokers or employees, aware of any circumstances, acts, errors, omissions, or any allegations or contentions of any incident which may result in a claim? Yes ☐ No ☐
   If "yes", please complete a separate Supplemental Claim form for each claim or suit and include a currently valued loss run for each claim.

7. After inquiry with each person as appropriate, have you, or any of your partners, officers, directors, solicitors, brokers, agents, or employees been the subject of any state Department of Insurance complaint during the past five (5) years or ever had your insurance license revoked or suspended? Yes ☐ No ☐
   If "yes", please provide an explanation of the circumstances and penalty involved. If available, please provide a copy of the complaint, your response, and a copy of the Bureau's decision.

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts. The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

(Must be signed by a Principal, Partner, or Officer of the Firm)

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____

ERRORS & OMISSIONS SUPPLEMENTAL CLAIM APPLICATION

INSTRUCTIONS:

1. This form is to be completed when the Applicant has been involved in any claim or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM OR INCIDENT.

2. If space is insufficient to answer any questions fully, attach a separate sheet.

3. In lieu of attaching suit papers, please provide a complete narrative description of the allegations involved.

1. Full name of Applicant: _____

2. Full name of Individual(s) or entity involved in the claim: _____

3. Additional defendants _____

4. Full name of Claimant: _____

5. Indicate whether: ☐ CLAIM ☐ SUIT ☐ Incident/Circumstance Only (no claim or suit)

6. Date and location of alleged act, error or omission: _____

7. Date of claim: _____ Date reported to Insurance Company: _____

8. What is the status of the claim? ☐ Closed/Settled ☐ Open/Pending ☐ Incident/Circumstance

9. IF CLOSED:

   Total paid including deductible(s)? Responses *such as "unknown" or "unavailable" are insufficient.*

	Defense costs	**Loss/compensatory damages**
Paid by you-out of pocket	$	$
Insurance Company	$	$

   Date Resolved: _____/_____/_____ ☐ Trial ☐ Out of Court

10. IF PENDING:
    (a) Claimant's settlement demand? $ _____ Defendant's settlement offer (if any): $_____
    (b) Insurer's reserve amounts? Loss $_____ Defense $_____
    (c) Amounts already spent defending the claim? By you? $_____ By the insurer? $_____
    (d) What is your best estimate of the likely settlement amount for this matter? $_____
    (e) What is your best estimate of the date when you expect this claim to be resolved? _____

    Note: Answering "unknown" or "unavailable" to the above questions is an insufficient response.

11. Name(s) of Insurer(s) responding to this claim or incident. _____
    Policy Number: _____
    Limits of Liability: _____ Deductible: _____

12. Provide narrative description of suit, claim or incident, including the allegations involved, the potential size of injury and your response: _____

13. Explain what action(s) have been taken to prevent reoccurrence of a similar claim: _____

I declare that the information submitted herein is true to the best of my knowledge and becomes a part of my Professional Liability Application. I understand that an incorrect or incomplete statement could void my protection.

_____

Signature of Applicant/Title/Date (Must be signed by a Principal, Partner or Officer of the Firm)