

SCOTTSDALE

SURPLUS LINES INSURANCE COMPANY

8877 North Gainey Center Drive
Scottsdale, Arizona 85258
1-800-423-7675 • Fax (480) 483-6752

Miscellaneous Professional Liability Application

Applicant Name: _____	Agent Name: _____
Mailing Address: _____	Address: _____
Phone Number: (____) _____	Agent #: _____

1. Form of business: ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company
2. Year business established: _____
3. Proposed effective date: From _____ To _____ 12:01 A.M., Standard Time at the mailing address.
4. Limit of Liability desired (each claim/annual aggregate):
- ☐ \$500,000/\$500,000
☐ \$500,000/\$1,000,000
☐ \$1,000,000/\$1,000,000
☐ \$1,000,000/\$2,000,000
☐ \$1,000,000/\$3,000,000
5. Policy Type: ☐ Claims-made ☐ Occurrence
6. Professional activities for which coverage is desired: _____
7. Is applicant engaged in any business or professional activity other than in Question 6.? ☐ Yes ☐ No
If Yes, include explanation with estimated annual receipts.
8. Gross receipts for past three years and projected gross receipts for current year for the professional activities described in Question 6.

	Gross Receipts
Current Year	\$ _____ estimate
1st Prior Year	\$ _____
2nd Prior Year	\$ _____
3rd Prior Year	\$ _____

9. For the current year projected Gross Receipts, please give the approximate percentage derived from each activity listed in Question 6.

Service	Approximate % of current year estimated Gross Receipts
_____	_____%
_____	_____%
_____	_____%
_____	_____%

10. Is the applicant controlled, owned or associated with any other firm, corporation or company? ☐ Yes ☐ No
If Yes, please provide full details.

Are any of the services described in Question 6. provided to such business enterprises? ☐ Yes ☐ No
If Yes, please provide details.

11. To what professional associations does the applicant belong? _____

12. Does the applicant use a written service contract? ☐ Always ☐ Sometimes ☐ Never

Please attach a sample copy of the contract used.

13. Number of employees:

_____ Principals, partners, officers and professional employees providing services to clients?

_____ Clerical employees (clerks, secretaries, etc.)

_____ Other (describe): _____

14. Please provide the following:

Name of Partner, Principal or Key Employee	Professional Qualifications	Date Qualified	Years of Experience	How long as a Partner/Principal?

15. Please list five (5) of the largest projects handled during the past three (3) years. Please provide:

Project or Client Name	Nature of the services performed	Revenues from services
1.		
2.		
3.		
4.		
5.		

16. What percentage of the applicant's business involves subcontracting work to others? _____ %

Are certificates of insurance, evidencing professional insurance, required? ☐ Yes ☐ No

Does Sub name applicant as additional insured on professional policy? ☐ Yes ☐ No

Does contract with Sub contain hold harmless in applicant's favor? ☐ Yes ☐ No

17. Has any insurance company or insurer declined, canceled or refused to renew any similar insurance for the applicant during the past five (5) years? ☐ Yes ☐ No

(Not applicable to Missouri applicants.) If Yes, please provide details: _____

18. Prior five (5) years Professional Liability Insurance carriers:

Name of Insurer	Period	Limit	Deductible	Claims-Made or Occurrence	Premium

19. Have any claims been made during the past five (5) years against the applicant, any of the present partners, employees or office workers, or to the applicant's knowledge, against any past directors, partners, officers, or employees?
☐ Yes ☐ No

If Yes, on a separate page please provide full claim details including status of claim, amounts demanded or paid, and dates of claims.

20. Is the applicant aware of any fact of circumstances, or any allegations, or contentions of any incident which may result in any claim being made against the applicant, or any of its past or present partners, executive officers, directors, office workers or employees, any predecessors in business, or against any corporation that the applicant was formerly employed by? ☐ Yes ☐ No

If Yes, please provide details on a separate page.

It is agreed that if such knowledge exists, any claim or action arising therefrom is excluded from this proposed coverage.

21. Please submit the following additional information with this application:

- (1) A brief resume for all principals, partners and officers
- (2) Copies of:
 - (a) advertisements, brochures and descriptive literature;
 - (b) sample service contract between applicant and client; and
 - (c) latest financial data (annual report and/or balance sheet)

Signing this form does not bind you to complete the insurance. Coverage will become effective upon approval of the application and issuance of the policy. It is agreed that this form will be the basis of a claims-made contract. Should a claims-made policy be issued, this form will be attached to and become a part of the policy.

APPLICABLE IN THE STATE OF NEW YORK:

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 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.

FRAUD 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 subjects such person to criminal and civil penalties.

The answers given to all the questions in this application are complete and correct to the best of my knowledge.

SIGNATURE OF APPLICANT

DATE

Agent's Name: _____

Agent's License Number: _____

(Applicable only in Florida)