

AGENT INFORMATION	Agency Name	State License No.	Agent No.
	Agency Address (Street, City, State, Zip Code)		
MAIL TO	St. Paul Financial and Professional Services		
UNDERWRITING COMPANY	St. Paul Fire and Marine Insurance Company		
IMPORTANT NOTE	<p><i>Insurance Agents or Brokers Professional Liability Protection is provided on a claims-made basis. Coverage for prior acts may be restricted with the use of a retroactive date in the policy.</i></p> <p><i>This application is not a representation that coverage does or does not exist for a particular claim or loss, or type of claim or loss, under any insurance policy issued by The St. Paul. Whether coverage exists or does not exist for a particular claim or loss under such policy depends on the facts and circumstances involved in the claim or loss and all applicable policy wording.</i></p> <p><i>NY DEFENSE EXPENSES NOTICE: If this policy contains an insuring agreement that includes defense expenses within the limits of coverage, and/or a deductible that applies to defense expenses, 100% of such limits or deductibles may be used up with the payment of judgments, settlements, or defense expenses. Once the limit of coverage is used up, we will have no further obligation to pay any judgments, settlements, or defense expenses.</i></p>		
INSTRUCTIONS	<p><i>Include the following information with this application</i></p> <ul style="list-style-type: none"> ● <i>Copy of any brochures or marketing materials.</i> ● <i>Copy of a recent, audited financial statement.</i> ● <i>Any additional information requested in this application.</i> 		

APPLICANT INFORMATION

1. Name of Applicant		2. Date Established	
3. Address (Street, City, State, Zip Code)		County	4. Telephone No. ()
5. Email Address	6. Web Address		7. Facsimile No. ()
8. Applicant is a(n): <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Other _____			
9. Desired limit of insurance (Each Wrongful Act / Total Limit): <input type="checkbox"/> 500,000/1,500,000 <input type="checkbox"/> 1,000,000/1,000,000 <input type="checkbox"/> 1,000,000/3,000,000 <input type="checkbox"/> Other _____			
10. Desired deductible (Each Wrongful Act): <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,500 <input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000 <input type="checkbox"/> 25,000 <input type="checkbox"/> Other _____			

OPERATIONAL POLICIES AND PROCEDURES

11. For each of the following does the applicant:
- a. Have an individual or committee who is responsible for errors & omissions loss control? Yes No
 - b. Conduct in-house audits to monitor compliance with errors & omissions prevention procedures? Yes No
 - c. Have an in-house orientation training program for all new employees? Yes No
 - d. Have an ongoing in-house training program for all employees? Yes No
 - e. Maintain a written office procedure manual for all personnel? Yes No
 - f. Have a procedure requiring that all in-coming mail be date-stamped? Yes No
 - g. Have a standard form or procedure for documenting key points of all telephone conversations? Yes No
 - h. Have a procedure requiring prompt written confirmation of all verbal binders to both client and insurer? Yes No
 - i. Maintain a centralized binder log system? Yes No
 - j. Provide its clients a written review of their limits and coverage at least once every three years? Yes No
If no, on a separate sheet attached to this application, explain the applicant's review procedure.
 - k. Provide written confirmation to its clients of their refusal to accept coverage or limits that the applicant has recommended? Yes No

- l. Provide written confirmation to its clients of any reduction(s) in current or proposed coverage(s)? Yes No
- m. Obtain client signatures confirming they have read and fully responded to all questions on the application?..... Yes No
- n. Obtain client signatures confirming their understanding of the potential consequences of misrepresentation in the application process? Yes No
- o. Have procedure in place to address both terrorism and mold exposures with each client?..... Yes No
- p. Obtain client signatures confirming their understanding when terrorism and/or mold coverage is not provided? Yes No
- q. Maintain a policy expiration list and confirm that all renewal policies and binders are issued? Yes No
- r. Review all policies and endorsements for accuracy and completeness before mailing to the insured? Yes No
- s. Have a procedure in place to review and understand all policy forms prior to use? Yes No
- t. Use coverage checklists for both commercial and personal lines clients? Yes No
- u. Review all excess policies to determine whether or not they are consistent with the underlying policies?..... Yes No
- v. Maintain a suspense system for following up on requested items?..... Yes No
- w. Have a procedure requiring all personnel to immediately notify a designated individual within the firm of any incident or occurrence that might give rise to an errors & omissions claim against the applicant? Yes No
- x. Review all incidents or claims for possible procedural changes that might reduce the potential for recurrence of the claim or incident?..... Yes No

12. Is the applicant owned:

- a. By any commercial bank, thrift association, savings & loan association, savings bank, or similar deposit taking financial institution? Yes No
- b. By any holding company, director, officer, or employee of a commercial bank, thrift association, savings & loan association, savings bank, or similar deposit taking financial institution? Yes No

If yes to either of the above, please provide the name of the deposit taking financial institution.

Name _____ City _____ State _____

- c. Is this deposit taking financial institution a member of a national trade association for banking?..... Yes No
Name of association: _____

- 13. a. Number of years current executive management has been in place: _____
(If less than 3 years, attach managers' résumés)
- b. Number of years current ownership has been in place: _____
(If less than 3 years, attach owners' résumés)

- 14. List name, address, and operation of each subsidiary, affiliate, and/or branch office *(attach a separate sheet, if necessary):*
If only one location, please check here .

Name	Address	Ownership	Operations

- 15. Does the applicant maintain Commercial General Liability insurance coverage? Yes No
If yes, please indicate limit of liability: Primary \$ _____; Excess/Umbrella \$ _____

16. During the last three years, has:

- a. The name of the applicant changed? Yes No
- b. There been a change in ownership of the applicant? Yes No
- c. The applicant merged with or acquired any other entity? Yes No

If yes to any part of question 16, please provide details on a separate sheet attached to this application.

- 17. Is the applicant, including any owner officer or employee, owned or controlled by or affiliated with, any other entity or organization (other than indicated in question 12)? Yes No

If yes, please provide details on a separate sheet attached to this application including name of the entity, operation of business, and percentage owned or controlled, and if applicant places any insurance coverage for such entity or organization.

18. In the table below provide the breakdown of the applicant's staff by location. Attach a separate sheet for more locations. **List each person in only one staff category. Include all active owners, partners, officers, salespersons, solicitors, independent contractors, and employees.**

Staff	Location 1			Location 2			Location 3		
	Full-time Staff	Part-time Staff	Total Weekly Hours For All Part-time Staff*	Full-time Staff	Part-time Staff	Total Weekly Hours For All Part-time Staff*	Full-time Staff	Part-time Staff	Total Weekly Hours For All Part-time Staff*
Licensed & Unlicensed Property & Casualty Staff									
Licensed & Unlicensed Life, Accident & Health Staff**									
Property & Casualty Independent Contractors									
Life Independent Contractors									
Risk Managers									
All Other Staff***									
TOTAL:									

***Total Weekly Hours** means the total number of combined hours worked for all part-time staff shown in each category.
 ****Life, Accident & Health Staff** means only staff who devote at least 90% of their time to the sale of Life, Accident & Health, Annuities, or Mutual Funds.
 *****All Other Staff** means all staff engaged in non-insurance related functions, and not providing services directly supporting insurance clients, such as accountants, information systems personnel, and human resource staff.

19. a. Indicate which describes the applicant's educational program specifically related to applicant agency's E&O risk management over the past two years:
- 5-10% of staff attended a course
 - 11-50% of staff attended a course
 - More than 50% attended a course
 - Consultant hired (without audit)
 - Consultant hired (including an audit)
 - None
 - Other (provide details on a separate sheet)
- b. What percentage of the applicant's licensed staff exceed state requirements for continuing education? %

COMPANIES REPRESENTED

20. a. Does the applicant have a procedure in place to select and approve all companies represented? *If yes, please provide details on a separate sheet.* Yes No
- b. List all insurance companies that business is placed with by the applicant (Attach a separate sheet if necessary). **Insurance company** includes any reinsurer, syndicate, association, or any other organization formed for the purposes of providing insurance or reinsurance.

Company Name and State of Domicile	Surplus Lines Company	Current A.M. Best Rating	Years Applicant Has Represented	Percent of Applicant Net Written Premium
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Yes <input type="checkbox"/> No			
TOTAL				100%

- c. List all insurance companies that either the applicant or the company have terminated the relationship during the past five years. *If none, check here* .

Company Name and State of Domicile	Surplus Lines Company	Date Representation Terminated	Reason for Termination
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

INSURANCE PLACEMENT PROCEDURES

21. Does the applicant have a procedure to review the carrier's financial rating before placing business with the carrier, renewing coverage, or requesting material changes to coverage (including non-admitted business placed through a broker)? *If yes, please answer the following:*..... Yes No
- a. What financial rating source is used?
 A.M. Best Co. Standard and Poor's Other _____
- b. How frequently is the financial rating reviewed?
 Monthly Semi-Annually Quarterly Annually Other (explain) _____
- c. Does the applicant have a procedure in place to notify employees of changes in a carriers financial rating? Yes No
22. Does the applicant review the type and amount of insurance placed with each carrier? Yes No
23. In instances where applicant places insurance with non-rated carriers, or carriers rated lower than A- by A.M. Best:
- a. Does the applicant advise the client in writing of the financial rating, or non-rated status of the carrier? Yes No
- b. Does the applicant provide the client with a written explanation of the hazards associated with placement of business with such carriers? Yes No
- c. Does the applicant obtain a signed acknowledgment of the above information from their clients?..... Yes No
24. Does the applicant notify clients in writing in the event of a carrier's insolvency or lowering of its financial rating? Yes No

APPLICANT SERVICES

25. Does the applicant provide any of the following:
- a. Financial Planning Services:***If yes, please provide the following:* Yes No
- 1) Gross revenue from the development of financial plans..... \$ _____
- 2) Gross revenue from the sale of annuities..... \$ _____
- 3) Gross revenue from the sale of mutual funds..... \$ _____
- 4) Gross revenue from the sale of variable life products \$ _____
- 5) Gross revenue from the sale of other securities (e.g. stocks) \$ _____
- 6) Number of staff providing these services _____
Please provide resume(s) for each staff member providing these services and a copy of form U-4 for any registered representatives.
- b. Plan Administration Services**..... Yes No
Please complete the Plan Administration Supplement if applicant provides any of the following services in conjunction with the administration of any insured or self-insured plan:
- Claims adjusting
 - Employee enrollment/education
 - Plan design
 - Software development
 - Web-site design/maintenance
 - Utilization reviews
 - Peer reviews
 - Credentialing
 - Plan funding/actuarial services
 - Cost containment services
 - Loss control/risk management
 - Stop-loss insurance placement (for self-insured plans)
- 1) Indicate applicant's gross revenues derived from this activity. \$ _____
- c. Underwriting Services**..... Yes No
Please complete the Underwriting Services Supplement if applicant is granted authority under contract with any insurer or reinsurer to provide any of the following services:
- Underwriting
 - Binding
 - Claims adjusting/administration
 - Policy Issuance
 - Actuarial Services
 - Loss Control
 - Appoint agents/extend agency agreements to other agencies
- 1) Indicate applicant's gross revenues derived from this activity \$ _____
- d. Other (Please explain)** _____
26. Does the applicant own or operate a premium finance company? *If yes, please answer the following:*..... Yes No
- a. Provide the name of the company: _____
- b. Indicate applicants gross revenues derived from this activity: \$ _____
- c. Indicate premium volume financed:..... \$ _____
- d. Are premiums financed for other than the applicant's insurance clients?..... Yes No
- e. Who handles collection of delinquent accounts:
 Applicant Collection Agency Other (describe) _____

27. a. Indicate all of the following services provided:

Type of Service	These Services are Provided by			% of total agency revenue	\$ Revenue for this service	% of this revenue for services provided to	
	Applicant	Independent Contractor selected by applicant <i>(List Contractor name)</i>	Others <i>(List Name/ Business Relationship)</i>			Applicant Insurance Clients'	Others
Environmental Audits	<input type="checkbox"/>						
Certified Training Programs	<input type="checkbox"/>						
OSHA Audits	<input type="checkbox"/>						
Industrial Hygiene Monitoring	<input type="checkbox"/>						
Writing Safety Programs	<input type="checkbox"/>						
	<input type="checkbox"/>						
	<input type="checkbox"/>						

*Attach a narrative description and any brochures or marketing material.
Explain on a separate sheet the applicant's role in the selection of any independent contractors or others.*

b. Is a certificate of errors and omissions insurance obtained annually from each individual when services are provided by someone other than the applicant? Yes No

c. In the following table list all employees and/or independent contractors indicated above (attach a separate sheet, if necessary):

Name of Individual Involved	Licenses Held	Professional Designations	Years of Experience

APPLICANT OPERATIONS

28. In the table below please provide the dollar amounts of applicant's premium and revenue (include all subsidiaries and branch offices):

	Most Recent 12-Months	Previous 12 Months	Projected Next 12 Months
Net Written Premiums			
Gross Revenues			

29. Describe your five largest clients:

Name of Client	Type(s) of Coverage(s) Written	Gross Premium Amount

30. Please complete the following for each of the applicant's top 5 producing agents or brokers:

Name	Revenue-Most Recent 12-Months	Specialty Area(s)	
		Industry	Line(s) of Business
1.			
2.			
3.			
4.			
5.			

31. Indicate the approximate percentages of the applicant's total business written in each category below. Columns A+B must = 100%.

Lines of Business	Percentage of Total Net Written Premium Column A	Lines of Business	Percentage of Total Net Written Premium Column B
COMMERCIAL LINES		PERSONAL LINES	
Automobile		Automobile (<i>standard</i>)	
Aviation		Automobile (<i>non-standard</i>)	
Bonds		Homeowners	
Directors and Officers Liability		Other (<i>explain</i>)	
Non-medical Professional Liability		ACCIDENT & HEALTH AND LIFE	
Medical Malpractice		A&H Group	
Ocean and Inland Marine		A&H Individual	
Excess and Surplus Lines		Annuities or Mutual Funds	
Workers Compensation		Life Group	
Standard Property & Casualty		Life Individual	
Other (<i>explain</i>):		Other (<i>explain</i>):	
Subtotal Column A		Subtotal Column B	
GRAND TOTAL (Columns A and B must equal 100%)			

NON-ADMITTED OR SURPLUS LINES BUSINESS

32. Is the applicant a licensed surplus-lines broker? Yes No
If yes:
- a. Does the applicant place business directly with any non-admitted or surplus-lines insurer? Yes No
- b. Indicate percentage of total business: _____%
 Total premium: \$ _____

BROKERED BUSINESS

33. Does the applicant place any business, including surplus lines business, through another agent or broker? Yes No
If yes:
- a. Percentage of total business: _____%
- b. Is a certificate of errors and omissions insurance obtained from each such agent or broker annually? Yes No
- c. Are written agreements in place holding the applicant harmless by each such agent or broker? Yes No
34. Does the applicant accept and place business for other agents or brokers? Yes No
If yes:
- a. Percentage of total business: _____%
- b. Is a certificate of errors and omissions insurance obtained from each such agent or broker annually? Yes No
- c. Are written agreements in place holding the applicant harmless by each such agent or broker? Yes No

APPLICANT HISTORY

35. Has the applicant or any member of the applicant firm (*including owners, officers, partners, principals, or employees*) been reprimanded, cautioned, investigated, license(s) revoked, or been involved in any suit or investigatory proceeding initiated by any regulator firm, professional review board, or similar body for actual or alleged violations arising out of professional activities?..... Yes No
If yes, please explain the full details and resolution of any such incident on a separate sheet attached to this application.

36. List the insurance agents or brokers professional liability (*errors & omissions*) insurance carrier for the past three years (*check if no insurance*):

Insurance Company	Limit of Liability (per claim/aggregate)	Deductible Or Retention	Policy Period	Expiring Premium	Retroactive Date, if any

37. During the past five years, has any insurance carrier declined, canceled, or refused to renew the applicant's professional liability (*errors & omissions*) insurance for any reason? (*not applicable in Missouri*)..... Yes No
If yes, please provide complete details including the name of the carrier, the date and reason for declination, cancellation or non-renewal on a separate sheet attached to this application.

PRIOR INCIDENTS AND LOSS INFORMATION

38. After inquiry, is any owner, officer, principal, partner, manager, or supervisor of the applicant aware of:
 a. Any professional liability claims against them, the applicant firm, or predecessor firm in the past five years? Yes No
 b. Any services or incidents that might reasonably be expected to lead to a claim or suit against them, the applicant firm or a predecessor firm?..... Yes No
If yes, to either question, please complete the Claim or Incident Supplement.

c. Please provide a loss run for the most recent 5 years.
 39. Missouri Residents Only: Requested Claims-Made Retroactive Date/Prior Acts Date:..... _____
 Check if none

IMPORTANT NOTE	Be sure to report all known claims, suits, or wrongful acts to your current insurer before the claims reporting period expires.
FRAUD WARNING NOTICE	If a state fraud warning notice applies, attach the signed Fraud Warning Notice List (Form 55306) to this application.

REQUIRED COMPLETION - READ AND SIGN

You, the undersigned, are the authorized representative of the prospective Named Insured and certify that reasonable inquiry has been made to obtain the answers to these questions. By signing, you certify that the answers and information that you provided in this application, and all supplements and attachments to this application, are true, correct, and complete to your best knowledge and belief. Signing this application won't constitute a binder or obligate St. Paul Fire and Marine Insurance Company to provide Insurance Agents or Brokers Professional Liability Protection, but it's agreed that this application will be the basis upon which a Policy may be issued.

Signature X	Date
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Applicant Name _____

Today's Date _____

UNDERWRITING SERVICES INFORMATION

1. Indicate which of the following Underwriting Services the applicant provides in conjunction with any underwriting authority granted under contract by any insurer or reinsurer. *Indicate the number of staff providing each service, and advise the maximum limit of your authority or highest level granted by any of your companies where requested.*

		No. of Staff	Max. Limit
a. Underwriting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
b. Binding	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
c. Claims Adjusting/Administration	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
d. Policy Issuance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
e. Actuarial Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
f. Loss Control	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
g. Appoint agents/extend agency agreements to other agencies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

2. How long has the applicant provided Underwriting Services? _____

3. Complete the following table for each program for which the applicant provides Underwriting Services. *Attach a separate sheet if necessary.*

Type of Insurance	Insurer or Reinsurer (attach copy of agreement(s))	Years Applicant Has Provided Underwriting Services	Premium Volume	No. of Sub Producing Agencies	Loss Ratio (Last 3 Years)

4. During the last five years, has any insurer or reinsurer for whom the applicant has provided Underwriting Services:

- a. Ceased operations or gone into receivership, insolvency or liquidation?..... Yes No
- b. Canceled, revoked or terminated any contract with the applicant? Yes No
- c. Increased applicant's binding, underwriting, or claim settlement authority?..... Yes No
- d. Imposed any new restriction on applicant's binding, underwriting, or claim settlement authority?..... Yes No

If yes to any of the above, please provide details on a separate sheet.

STAFFING INFORMATION

5. Provide the name and qualifications, and attach resumes, for all individuals responsible for managing applicant's Underwriting Services activities. *Attach a separate sheet if necessary.*

6. Describe applicant's organizational structure or provide an organizational chart.

UNDERWRITING ACTIVITIES

7. During the last five years, has the applicant, its employees or affiliates done any of the following:

- a. Owned, in whole or in part, any reinsurance company or reinsurance broker or intermediary, or been owned by or affiliated with any of these?..... Yes No
- b. Negotiated, placed or bound any reinsurance?..... Yes No
- c. Settled claims with, or on behalf of, any reinsurer? Yes No

If yes to any of the above, please provide details on a separate sheet.

8. Has any business for which underwriting services have been provided been placed directly or indirectly with any insurer, syndicate, captive or reinsurer of any kind that was or is domiciled outside of the United States (including Lloyds or the London Market) within the last five years? Yes No

If yes, please provide the following:

Name of Insurer	Insurer's Country of Domicile	Insurer's Current Best's Rating	Lines of Insurance Placed	Current Annual Premium Volume

9. During the last five years, has the applicant been involved in the formation, management, or administration of any of the following:
- a. Multiple employer welfare trust (MEWA) or multiple employer trust (MET) Yes No
 - b. Self Insurance pools, trust, captives, or other self insurance entities..... Yes No
 - c. Risk retention groups or risk purchasing groups Yes No
 - d. Health maintenance organizations or preferred provider organizations..... Yes No

If yes to any of the above, please provide the following:

Name of Entity	Type of Entity	Date of Formation	Current Number of Insureds	Lines of Insurance Placed	Current Annual Premium Volume

POLICIES AND PROCEDURES

10. Does the applicant have contracts or written agreements in place with:
- a. All agents and brokers who place business through the applicant?..... Yes No
 - b. All insurers and reinsurers for whom Underwriting Services are provided?..... Yes No
- If yes to either a or b above, do all such contracts and/or written agreements contain unilateral hold harmless or indemnification clauses?* Yes No
11. Do the applicant's contracts with each insurer and reinsurer contain record retention guidelines?..... Yes No
12. How often is the applicant audited by its insurers and reinsurers? *Attach a separate sheet if necessary.*

Insurer	Number of On-Site Audits Per Year

13. Does any insurer or reinsurer for whom the applicant provides Underwriting Services have an ownership interest in the applicant, or does the applicant have ownership interest in any such insurer or reinsurer? *If yes, please provide details on a separate sheet.* Yes No

CLAIMS ADJUSTING/ADMINISTRATION

14. If Claims Adjusting/Administration activities are indicated in question number 1, please complete parts a through g below.
- a. Is the applicant, and all individual claim adjusters, licensed in all states where they handle claims?..... Yes No
 - b. List all states in which the applicant handles claims.

 - c. Do any of the applicant's claim adjusters have an office at any client location? *If yes, please provide details on a separate sheet.*..... Yes No
 - d. Describe the applicant's after hours claim reporting capabilities. *Attach a separate sheet if necessary.*

 - e. Describe the applicant's procedure for denying benefits of coverage. *Attach a separate sheet if necessary.*

 - f. Describe the applicant's authority for the payment of claims. *Attach a separate sheet if necessary.*

 - g. Attach a copy of the applicant's claim handling guidelines.

LOSS HISTORY

15. During the last ten years, have there been any errors and omissions incidents or claims resulting from Underwriting Services activities? *If yes, please provide details on a separate sheet.*..... Yes No

INSTRUCTIONS

Complete this supplement if Plan Administration Services are indicated in question 25b of the Insurance Agents or Brokers Professional Liability Application Form 25827. Be sure to include all attachments indicated in question number 16 of this supplement.

APPLICANT INFORMATION

1. Name of Applicant

2. Applicant's gross revenues generated from all Plan Administration activities:

	Year	Revenue
Current Year		
Past Year		
Next Year Projected		

STAFFING INFORMATION

- 3. a. Number of claim adjusters:
- b. Number of support staff:.....
- c. Ratio of claim supervisors to claim handlers:.....
- d. Average number of assignments per month per handler:
- e. Average number of pending claims per handler:.....

4. Please provide the following with regard to all professional staff involved in Plan Administration:

Name	Qualifications	Years Plan Administration Experience

PLAN INFORMATION

5. Complete the following for each plan the applicant administers (attach a separate sheet if necessary):

Plan Name	Plan Sponsor	Years Administered	Type of Plan(s)	Services Provided*	Plan is: a. Self Funded With Stop-Loss b. Self-Funded Without Stop-Loss c. Fully Insured	Plan Audited By: a. Applicant b. Plan Sponsor c. Outside Firm	No. of Audits Per Year

*Indicate the services provided by the applicant for each plan by noting the corresponding letter(s) shown below in the Services Provided column above:

- a. Claims adjusting
- b. Employee enrollment/education
- c. Plan design
- d. Software development
- e. Web-site design/maintenance
- f. Utilization reviews
- g. Peer reviews
- h. Credentialing
- i. Insurance placement (stop-loss)
- j. Plan funding/actuarial
- k. Cost containment services
- l. Loss control/risk management
- m. Other _____
- n. Other _____

APPLICANT SERVICES

6. Is the applicant involved in the formation, management, or administration of any HMO, PPO, RRG, RPG or other similar entity? *If yes, please provide details on a separate sheet.* Yes No
7. Is the applicant responsible for managing funds associated with the plans administered? *If yes, please provide complete details on a separate sheet.* Yes No
- a. Is there a procedure in place for reconciling these funds? Yes No
8. Does the applicant firm, its partners, directors, officers or employees act as a trustee for any client? *If yes, please provide complete details on a separate sheet?* Yes No

POLICIES AND PROCEDURES

9. Has the applicant developed a policy or procedure manual to assist in complying with individual plan administration guidelines? Yes No
10. Describe the applicant's procedure for denying benefits or coverage:

11. Describe the applicant's authority for the payment of claims:

12. Describe the applicant's procedure for handling client or insured complaints:

13. Describe how the applicant keeps informed of changing legal requirements relating to the plans administered:

OTHER INSURANCE

14. Does the applicant maintain:
- a. Directors, officers and trustees liability insurance? Yes No
- b. A fidelity bond? Yes No
- c. Fiduciary liability coverage? Yes No
15. During the past five years, have any claims been made against any of the above policies? *If yes, please provide details on a separate sheet.* Yes No

ATTACHMENTS

16. Attach the following for each plan administered:
- Contractual Agreement
 - Service Agreement
 - Marketing Brochures
 - Certificates of Insurance for current Fiduciary, Fidelity, and D&O Policies
 - Claim Account Flowchart
 - Résumés of Key Personnel Involved in Plan Administration

COMPUTER PROFESSIONALS SUPPLEMENT

INSTRUCTIONS: Complete this supplement if you are directed to do so by your underwriter or as part of of your application.

Applicant Name

PRODUCT/SERVICE INFORMATION

- 1. What percentage of your total revenue is package (shrink-wrap) software? ...%
2. What percentage of your total revenue is custom software development? ...%
3. What is the cost of your average and largest computer product/software/service or project:
a. Average? ...\$
b. Largest? ...\$
4. Please check all the areas in which your software or services have application:
[] Accounting [] Inventory Management
[] Financial (checking, dividend accounts) [] eCommerce
[] Investments [] Architectural Design
[] Funds Transfer [] Graphic/Presentation Materials
[] Database Management/Administrative [] CAD/CAM Design or Control
[] Credit Card Processing [] Billing Systems
[] Operation of Utilities [] Office Automation
[] Facilities Management [] LAN/Network Management
[] Process Control [] Pollution Control/Environmental
[] Equipment Operation [] Other (describe):
5. Please indicate the industries for which you provide software or computer services:

BUSINESS OPERATIONS

- 6. Are all programs and changes documented, tested and the results retained for the active life of each program? ... [] Yes [] No
7. What is the worst thing that could happen to your customers' operations if your product/service were to fail or stop working?
8. Describe any computer operations or products discontinued within the last five years?
9. Do you use subcontractors for any of your services? ... [] Yes [] No
If yes, please describe any and all services provided below.

FRAUD WARNING NOTICES

Fraud Warning Notice: If a state fraud warning notice applies, please attach form #55306 to this application.

REQUIRED COMPLETION - READ AND SIGN

This supplement must be signed and dated by an owner, principal, partner, or officer of the applicant firm. It is agreed that the applicant's responses to the questions contained in this supplement are material and that this information becomes part of the applicants Professional Liability Application and is subject to the same terms and conditions.

Authorized Representative (<i>Owner, Partner, or Officer of Applicant</i>)	Title	Date
X		

eCOMMERCE SUPPLEMENT

INSTRUCTIONS: Complete this supplement if you are directed to do so by your underwriter or as part of your application.

Applicant Name _____

eCOMMERCE ACTIVITIES

1. Please identify your internet site(s), the date each site first went on-line, and the average number of page-views per month:

Internet Site (including URL)	Date on-Line	Average Page Views Per Month

IMPORTANT: If any of the above sites are not yet on-line, please attach a complete description of the proposed site(s).

2. Do you own a federally registered trademark in your domain name? Yes No
 If no, have you conducted a trademark search to determine whether your domain name infringes a trademark held by a third party?..... Yes No

3. Do any of your internet sites contain any of the following content, transact business in any of the following areas, or sell/make available any of the following products or services:

- a. Pornographic material or other material of a sexually explicit nature? Yes No
- b. Medical records or other health care information pertaining to specifically identifiable patients? Yes No
- c. Financial services, including banking, insurance, or investment services? Yes No
- d. Gambling, lotteries or other games of chance?..... Yes No
- e. Professional services, such as legal services, accounting services, medical services or other services which must be provided by licensed professionals?..... Yes No
- f. Music available to be downloaded by users?..... Yes No

4. Do you collect personal information (names, addresses, etc.) about visitors to your internet site(s)?..... Yes No
 If "Yes," do you sell or otherwise disclose this personal information to third parties?..... Yes No
 If "Yes," to either of the foregoing questions, do you disclose these activities to visitors to your site(s)?..... Yes No

5. Is electronic commerce conducted on any of your internet sites? Yes No
 If "Yes": Are the transactions encrypted? Yes No
 Do you process the transactions yourself (as opposed to using an independent contractors)? Yes No

6. Please describe the security system(s) you have in place to prevent unauthorized access to credit card data and other confidential material on your site(s):

7. Do you provide links on any of your internet sites to internal pages of other sites? Yes No
 If "Yes," do you obtain written permission from the operators of such other sites? Yes No

8. Do you sell advertising space on any of your internet sites? Yes No

9. Do you utilize any proprietary software in the operation of any of your internet sites? Yes No

10. Do you provide software on any of your internet sites that can be downloaded by users?..... Yes No
 If "Yes," do you own all of the rights necessary to disseminate this software?..... Yes No

11. What percentage of the content on your internet site(s) is obtained from third parties? _____%

12. With respect to the internet content that you obtain from third parties:

- a. Do you obtain written permission from such third parties? Always Sometimes Never
- b. Do you obtain written indemnification agreements from such third parties?..... Always Sometimes Never

If you answered "Sometimes" or "Never" to either of the foregoing questions, please explain your policy regarding use of third-party content:

RISK MANAGEMENT

- 13. Do you use third-party trademarks on your internet site(s) solely in order to increase the number of hits to your site(s)? Yes No
- 14. Do you have in-house counsel or outside counsel to advise you regarding potential legal liabilities arising out of content on or transactions conducted over your internet site(s)? Yes No
- 15. Do you have a privacy policy posted on all of your internet site(s)? Yes No
If "Yes," has the privacy policy been reviewed by counsel?..... Yes No
- 16. Do you have a written policy and procedure regarding the posting of content on the internet site(s) identified in the supplement?..... Yes No
- 17. Do you require review of content by legal counsel or by management for potential legal exposures prior to allowing that content to be posted on your internet site(s)?..... Yes No
- 18. Do you have "take-down" procedures in place for removing from your internet site(s) any content that infringes or potentially infringes on copyrights held by third parties? Yes No

FRAUD WARNING NOTICES

Fraud Warning Notice: If a state fraud warning notice applies, please attach form #55306 to this application.

REQUIRED COMPLETION - READ AND SIGN

This supplement must be signed and dated by an owner, principal, partner, or officer of the applicant firm. It is agreed that the applicant's responses to the questions contained in this supplement are material and that this information becomes part of the applicants Professional Liability Application and is subject to the same terms and conditions.

Authorized Representative (<i>Owner, Partner, or Officer of Applicant</i>)	Title	Date
X		

Complete one form for each claim, suit, or incident.

Name of applicant or insured _____

Name of individual(s) at firm involved in the claim or incident _____

Name of claimant _____

This matter is currently a/an:
 Pending demand, claim, or suit Closed matter Incident

Name of insurer to whom this matter has been reported	Date reported to insurer
---	--------------------------

If this matter is a pending claim or suit, complete this section

Date of alleged error	Date of claim	Additional defendants, if any
Claimant's settlement demand \$	Defendant's offer for settlement \$	Insurer's loss reserve \$
Cost of defense paid to date \$	Is claim in suit \$	If claim is in suit, amount asked in summons \$

If this matter is closed, complete this section

Date of alleged error	Date of claim	Additional defendants, if any
Total paid indemnity \$	Total paid defense costs \$	Deductible \$

Indicate whether
 Matter closed without payment Court judgement Out of court settlement

If this matter is an incident only, complete this section

Date of alleged error _____

Description of claim, suit, or incident - Provide enough information to allow evaluation. Attach a separate sheet, if necessary. DO NOT attach a copy of the summons:

Alleged act, error, or omission upon which claimant bases claim:

Description of case and events:

Description of the type and extent of injury or damage allegedly sustained:

Description of Risk Management Procedures

Describe any remedial measures taken by the applicant or insured to avoid similar claims or incidents:

IMPORTANT: Claim Reporting Requirement

Completion of this supplement does not substitute for reporting this Claim, Demand, Suit, or Incident to the Claims Department of your insurer. You must report all such matters to the Claims Department of your insurer separately and before the claims reporting period provided under your current policy ends.

REQUIRED COMPLETION - READ AND SIGN

You, the undersigned, are the authorized representative of the prospective Named Insured and certify that reasonable inquiry has been made to obtain the answers to these questions. By signing, you certify that the answers and information that you provided in this supplement and attachments to this supplement, are true, correct, and complete to your best knowledge and belief.

Signature

X

Date

**NEW YORK APPLICATION AND INTRODUCTION PAGE ADDENDUM
CLAIMS-MADE DISCLOSURE AND NOTICE**

Please read the following claims-made disclosures and notices carefully:

- The insuring agreement, if issued, will be written on a claims-made basis.
- If this agreement includes a retroactive date, no coverage is provided for claims or suits arising out of wrongful acts committed prior to the retroactive date.
- The insuring agreement applies only to the following:
 - Covered claims or suits first made or brought while the agreement is in effect.
 - Covered wrongful acts first reported to us while the agreement is in effect.However, except for the limited reporting period, all coverage under the agreement ends if the agreement is canceled or not renewed and an Extended Reporting Period Endorsement is not purchased.
- The length of time for the limited reporting period is 60 days.
- The lengths of time that are available to you for an Extended Reporting Period Endorsement are 12 months, 24 months, 36 months, or an unlimited time period (unlimited time period not applicable to Miscellaneous Errors And Omissions Liability Protection - Claims-Made).
- If the length of time for the Extended Reporting Period Endorsement is less than an unlimited time period, potential coverage gaps may arise upon expiration of the extended reporting period.
- During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates, and you can expect substantial annual premium increases, independent of overall rate-level increases, until the claims-made relationship reaches maturity.
- The premium for the Extended Reporting Period Endorsement will be based on the rates and rules in effect at the time the most current policy period began. The premium charges for the available extended reporting period options are shown in the Coverage Summary, which is a part of the policy.

FRAUD WARNING NOTICE LIST

This supplemental application notice is incorporated into and becomes part of your application to The St. Paul Companies, Inc. and its subsidiaries.

ARIZONA, ARKANSAS, CALIFORNIA, DISTRICT OF COLUMBIA, FLORIDA, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, PENNSYLVANIA AND VIRGINIA FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine and Virginia, insurance benefits may also be denied.

COLORADO FRAUD WARNING: 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 policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

HAWAII FRAUD WARNING: 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 of punishable by fines or imprisonment, or both.

NEW YORK AUTO FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.

OHIO FRAUD WARNING: 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.

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

TENNESSEE FRAUD WARNING: 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. If this is a Workers' Compensation policy, the following applies: It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

UTAH WC FRAUD WARNING: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

Applicant's Signature _____ Date _____
Agent's Signature _____ Date _____