

INSURANCE AGENTS LICENSED LESS THAN 3 YEARS

INSTRUCTIONS TO THE APPLICANT:

Please complete this Application and Supplemental Questionnaire and answer all questions. All forms must be signed and dated by you within 30 days of the desired effective date of coverage. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.

I. Agency Information

- Applicant's Legal Name: _____
- DBA Name: _____
- Address: _____ City: _____ State: _____ Zip: _____
- Contact Name: _____ No. of Locations: _____ State(s): _____
- Phone: _____ Fax: _____ Website Address: _____
- Email Address: _____
- Agency is a: Corporation Sole Proprietorship Partnership LLC Other: _____
- Date Entity Established: ____/____/____
- Current E&O carrier: _____ Retroactive Date: ____/____/____ Desired Eff. Date: ____/____/____
- Desired Limits of Liability (each claim/aggregate limit applies):
 \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000
- Desired Deductible (loss and defense): \$2,500 \$5,000

(IF YOU CURRENTLY HAVE COVERAGE, ATTACH COPY OF YOUR CURRENT E&O DECLARATIONS PAGE)

II. General Operations Information

1. Please provide commission income information of the operations.

| Type of Income | Last 12 months (f applicable) | Next 12 months (projections) |
|----------------------|-------------------------------|------------------------------|
| P&C Commissions | \$ | \$ |
| Life/A&H Commissions | \$ | \$ |
| Other (describe): | \$ | \$ |

2. Indicate the total number of Staff in your entity (include owners, principals, partners, etc.) and attach copy of license(s):

Licensed staff: _____ Independent contractors: _____ Non-Licensed staff: _____

3. Have any agents requesting coverage been the subject of disciplinary action as a result of professional activities? Yes No

4. Have any agents requesting coverage been convicted of a felony within the previous five years? Yes No

5. In the past 5 years, number of E & O claims: 0 1 2 3 or more. Total Amount Paid \$ _____

6. Does the Applicant have any knowledge of any potential errors or omissions claim(s)? Yes No

7. Has the Applicant ever had E&O coverage declined, cancelled or refused renewal? (Not applicable in MO) Yes No

(If yes to any of the above [# 3-7], please provide details by attachment to this application)

8. Are you acting as an MGA, PA, Wholesaler or Surplus Lines Broker who accepts business from other agents? Yes No

9. Provide the percentage of business placed with: Direct with carriers: _____% and/or through a Wholesaler or MGA: _____%

10. Provide the percentage of business placed with carriers that are: Admitted: _____% and/or Non-Admitted: _____%

11. Do you only place business with carriers that are rated B+ or ABOVE by A.M. Best? Yes No

If No, please indicate the percentage of business placed with carriers rated LESS than B+ by A.M. Best: _____%

12. List top 4 insurance carriers business is placed with or will be placed with. Include the revenues (your commission) or projected revenues derived from each placement:

| Insurance Carrier | Revenues | Insurance Carrier | Revenues |
|-------------------|----------|-------------------|----------|
| 1. | \$ | 3. | \$ |
| 2. | \$ | 4. | \$ |

13. Provide the percentage of commission income derived from: Personal Lines: _____% Commercial Lines: _____%
 Life & Health: _____%

14. Please indicate the percentage of the revenue derived from the following. **PLEASE NOTE, THE TOTAL LINES OF BUSINESS LISTED BELOW MUST EQUAL 100% AND MUST REFLECT THE PERCENTAGES SHOWN IN QUESTION 13.**

| PERSONAL LINES | | COMMERCIAL LINES | |
|------------------------------------|---|-------------------------|--------------|
| Auto (Standard) | % | Auto (Nonstandard) | % |
| Auto (Non-standard)/Motorcycles | % | Auto (Standard) | % |
| Homeowners | % | Aviation | % |
| Non-Standard Property | % | Bonds – All Other | % |
| Pleasure Boats/Craft | % | Bonds – Surety | % |
| Umbrella | % | Crop/Hail | % |
| Other (Describe) | % | D & O | % |
| LIFE, ACCIDENT & HEALTH | | Equine/Livestock | % |
| Equity Indexed Products | % | General Liability | % |
| Fixed Annuities | % | Inland Marine | % |
| Group Accident & Health | % | Long Haul Trucking | % |
| Group Life | % | Medical Malpractice | % |
| Individual Accident & Health | % | Product Liability | % |
| Individual Life | % | Professional Liability | % |
| Long Term Care/Disability | % | Property (Non-standard) | % |
| Mutual Funds | % | Property (Standard) | % |
| Securities | % | SMP/BOP/Package | % |
| Variable Annuities | % | Umbrella/Excess | % |
| Variable Life | % | Wet Marine | % |
| Viatical Settlements | % | Workers Compensation | % |
| Other (Describe): | % | Other (Describe): | % |
| | | | |
| | | TOTAL | 100 % |

15. Do you own, manage or place any coverage in any of the following? Yes No

If Yes, please check applicable box(s) providing details:

- | | | |
|--|--|--|
| <input type="checkbox"/> Multi Employer Welfare Arrangement (MEWA) | <input type="checkbox"/> Pool, Syndicate or Association | <input type="checkbox"/> Risk Retention Group (RRG) |
| <input type="checkbox"/> Preferred Employer Organization (PEO) | <input type="checkbox"/> Captive or Self Insurance | <input type="checkbox"/> Risk Purchasing Group (RPG) |
| <input type="checkbox"/> Health Maintenance Organization (HMO) | <input type="checkbox"/> Preferred Provider Organization (PPO) | <input type="checkbox"/> Premium Finance Company |

HAD A CLAIM? PLEASE PROVIDE A COPY OF ANY PREVIOUS ERRORS AND OMISSIONS CARRIER(S) LOSS RUNS OR A SUPPLEMENTAL CLAIM NARRATIVE. LOSS RUNS MUST BE DATED WITHIN THE PAST 60 DAYS.

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR OPERATIONS NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and
2. Each of the statements and answers given in this Application are:
 - a. Accurate, true and complete to the best of your knowledge;
 - b. No material facts have been suppressed or misstated;
 - c. Representations you are making on behalf of all persons and entities proposed to be insured;
 - d. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
3. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

FRAUD WARNING:

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for 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 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

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 insurer files a statement of claim or an application 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 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 purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MINNESOTA APPLICANTS: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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 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.

NOTICE TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he 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 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 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.

NOTICE TO TENNESSEE & 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.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

The applicant must sign this Application within thirty (30) days from the effective date prior to the policy inception date.

Signature of Applicant

Date

Print or Type Name and Title

CBMALAGA
Insurance Services LLC

SUPPLEMENTAL INSURANCE AGENT QUESTIONNAIRE

1. Do you only represent insurance companies rated A- or better by AM Best?

Yes
 No

2. Do you produce or project an average of less than \$300,000 in premium for each producing licensed agent?

Yes
 No

3. Do you have standard office procedures in place for all aspects of customer service including, but not limited to, checking for accuracy, adequate coverage & limits, documentation, follow up and renewal planning?

Yes
 No

4. How often do you review policy records to ensure quality of coverage for your customers?

Never
 Annually
 Every six (6) months
 Every three (3) months

5. Other than education required by the state of licensure as an Insurance Agent, do you hold or are you working towards any professional insurance designations? If so, please list.

Yes; _____
 No

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE BY ME ON THIS SUPPLEMENTAL QUESTIONNAIRE MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT. BY COMPLETING THIS QUESTIONNAIRE. I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED TO ME OR THAT A POLICY OF INSURANCE WILL BE ISSUED . IT IS UNDERSTOOD THAT IT IS MY RESPONSIBILITY TO PROVIDE PROOF OF THE INFORMATION ABOVE AND IS AVAILABLE UPON REQUEST AT ANY TIME.

I understand this information becomes a part of my application for professional liability insurance.

Signature of Applicant/Representative

Date

Print Name