All City Insurance
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ADJUSTING, APPRAISAL, CLAIMS ADMINISTRATION, INVESTIGATOR, ATTORNEY SERVICES/PROCESS SERVICE, AUDIT & INSPECTIONS

INFORMATION HEREIN IS CONSIDERED CONFIDENTIAL

1. Applicant's Name (include all firm names, trading names or DBA's under which you operate)

☐ Individual
☐ Partnership
☐ Corporation

Address: ______________ City: ______________ State: ______________ Zip: ______________

Tele: ( ) ______________ Fax: ( ) ______________ Month/Year firm established under current ownership: ______________

Internet Address: ______________

List any Branch Offices: ______________ Professional Organizations to which firm belongs: ______________

Name of Firm Principles	Title	Years of Experience	Professional Designations

2. DESCRIPTION OF OPERATIONS (Please indicate percent of revenues. If you are involved in several of the areas listed below, the total for ALL areas must equal 100%.)

ADJUSTER
- Property ______%
- Casualty ______%
- Workers Comp. ______%
- Liquor Liability ______%
- Environmental ______%
- Marine (Post-Occ.) ______%
- Professional Liability ______%
- Aviation ______%
- Catastrophe ______%
- Public Adjusting ______%
- Other, please explain ______%

____

APPRAISER
- Insurance-Related Appraisal ______%
- Non-Insurance Appraisal ______%
- Business Valuations ______%
- Real Estate Appraisal ______%
- Other, please explain ______%

____

CLAIMS ADMINISTRATION
- Workers Compensation ______%
- Property/Casualty ______%
- Life/Health/Disability (TPA's) ______%
- Self-Insureds ______%
- Loss Control Activities ______%
- Other, please explain ______%

____

AUDIT & INSPECTION
- Safety Engineer ______%
- Loss Control ______%
- Marine Condition/Value ______%
- Underground Storage Tanks ______%
- Insurance Premium Audits ______%
- Other, please explain ______%

____

ATTORNEY SERVICE
- Process Service ______%
- Paralegal Services ______%
- Photocopying (Legal or Med.) ______%
- Legal Support ______%
- Polygraph Examination ______%
- Other, please explain ______%

____

INVESTIGATOR
Investigations for:
- Insurance Cos./Court System ______%
- Private Corps./Individuals ______%
- Financial Institutions ______%
- Repossessions ______%
- Background/Credit ______%
- Other, please explain ______%

____

FORENSIC/EXPERT WITNESS
- Indicate Specialty: ______%
- Expert Testimony ______%
- Litigation Support and Consultation ______%
- Accident Reconstruction ______%
- Pre-Market Testing ______%
- Post-Occurrence Product Testing ______%
- Design Work ______%
- Other, please explain ______%

____

Do you engage in security-related services, such as alarm installation, patrol services, security guard or escort services? ☐ Yes ☐ No
Average Caseload per individual per month _________
Do you act as an agent or broker in the placement of insurance coverage? ☐ Yes ☐ No
Will you issue reservation of rights or declination of coverage letters? ☐ Yes ☐ No
If Yes, is this authority defined in writing from the carrier? ☐ Yes ☐ No
Do you have a fee collection process which minimizes the need to file suit to collect your fees? ☐ Yes ☐ No

Please describe your professional activities: _____

3. GENERAL INFORMATION

A. After diligent inquiry, has the Applicant or any of its predecessors in business, subsidiaries, affiliates, past or present partners, owners, salespersons, employees, or independent contractors:

1. Been investigated or are currently under investigation and/or cited by any regulatory agency, professional review board, or any similar body for violations arising out of your activities? ☐ Yes ☐ No If yes, please attach an explanation.
2. Been convicted of a felony? ☐ Yes ☐ No If yes, name the court and describe the nature of the conviction.
3. Had a professional license expired, been suspended or revoked? ☐ Yes ☐ No If yes, identify the state, agency, date and reason for the suspension or revocation.
4. Had an application for a professional license been denied? ☐ Yes ☐ No If yes, please attach an explanation.
5. Had any claims or lawsuits during the past 5 years? ☐ Yes ☐ No If yes, please complete the attached Supplement Claim Form.
6. Learned of any incidents, circumstances, acts, errors, or omissions that could result in a claim being made against them? ☐ Yes ☐ No If yes, please complete the attached Supplement Claim Form.

B. Gross Revenues (all sums billed for services rendered)
Actual for past fiscal year: $ ____________________
Estimate for coming fiscal year: $ ____________________

C. Number of Individuals employed by Firm

Professional Staff:	________ Full Time	________ Part Time
Independent Contractors:	________ Full Time	________ Part Time
Clerical:	________ Full Time	________ Part Time
Other (Please Specify) ____________________	________ Full Time	________ Part Time

What percentage of your gross revenue is generated by independent contractors? _____%
What percentage of your Professional Staff have worked for you for over two years? _____%

D. List your top three clients, type of services performed and percentages of annual gross revenues. (This information is needed for underwriting purposes only and is considered confidential between the Applicant and the Company.)

Client	Description of Services	Percentage of Revenue
1.		
2.		
3.		

E. Do you use any promotional material? ☐ **Yes** ☐ **No** **If yes, please attach a copy.**

F. Do you require a written contract or agreement for services you provide to your clients? ☐ **Yes** ☐ **No**
If yes, please attach a sample.

4. PREVIOUS COVERAGE INFORMATION: List each Carrier for the past 3 years. If none, state none.

A.

Carrier	Policy Period	Limits	Deductible	Premium

B. Does your current coverage include General Liability? ☐ **Yes** ☐ **No**
Is your current coverage written on a Claims-Made Form? ☐ **Yes** ☐ **No** **If yes, what is your retroactive date?** _______

C. Has any application for similar insurance made on behalf of the firm, its present partners, or any of its predecessors in business been declined, or has any such insurance been canceled, rescinded or refused renewal? ☐ **Yes** ☐ **No** **If yes, please attach a brief explanation.**

PLEASE NOTE: If you currently have Errors & Omissions coverage in place on a claims-made form, you may want to purchase prior acts coverage. For a quote, please include a copy of your current declarations page evidencing continuous claims-made coverage back to the retroactive date you desire.

5. QUOTE REQUEST

Please indicate which limit and deductible you would like quoted.

LIMITS*

☐ $100,000/$300,000
☐ $200,000/$600,000
☐ $300,000/$600,000
☐ $500,000/$1,000,000
☐ $1,000,000/$1,000,000
☐ $2,000,000/$2,000,000
☐ Other

DEDUCTIBLE

☐ $0
☐ $2,500
☐ $5,000
☐ $10,000
☐ Other

***Limits of Liability to $10 million are available**

NOTICE TO APPLICANT — PLEASE READ CAREFULLY

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 MAINE AND VIRGINIA, INSURANCE BENEFITS MAY ALSO BE DENIED

SIGNATURE AND AGREEMENTS

THE APPLICANT AND FIRM ACCEPT NOTICE THAT ANY POLICY ISSUED WILL APPLY ON A “CLAIMS-MADE” BASIS.

The undersigned is authorized by and acting on behalf of the Applicant and represents that all statements and particulars herein are true, complete and accurate and that there has been no suppression or misstatement of fact and agrees that this application shall be the basis of coverage and become a part of any Policy issued by the Company.

THE APPLICANT ACCEPTS NOTICE THAT HE/SHE IS REQUIRED TO PROVIDE WRITTEN NOTIFICATION TO THE COMPANY OF ANY CHANGES IN THE RESPONSES GIVEN TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE.

Except to such an extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED and reported to the company while the policy is in force and which arise from services performed on or after the Retroactive Date of the policy.

NOTE: THE APPLICATION MUST BE SIGNED BY AN ACTIVE OWNER, PARTNER, OR EXECUTIVE OFFICER.

Signature of Applicant and Title ____________________ Date ____________

SIGNING THIS FORM OR SENDING PREMIUM WITH THIS APPLICATION NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.