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| **Errors and Omissions Application** |
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| **NOTES:** | **This is a Claims Made policy** |
|  | **All questions must be answered** |
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| **General Information** |
| Legal Name of Applicant |       |
| Key Contact |       |  | Position |       |
| Mailing Address |       | Postal Code |       |
| Phone |       |  | Fax |       |
| Email |       |  | Website |       |
| Key Broker Contact |       |
| Brokerage Name |       |
| Brokerage Address |       | Postal Code |       |
| Phone |       |  | Fax |       |
| Email |       |  | Website |       |
| Applicant’s operations (including activities, programs, events, U.S. or international exposures) |
|       |
| Present Insurer |       |
| Expiry Date (dd/mm/yy) |       | Premium  | $ |       |
| Is the present insurer(s) offering renewal? |  | YES |       | NO |       |
| If "NO", provide full details |  |  |  |  |  |
|       |
| Are they restricting coverage in any way? |  | YES |       | NO |       |
| If "YES", provide details |  |  |  |  |  |
|       |
| Is the Applicant controlled, owned or associated with any other company, firm or corporation? | YES |       | NO |       |
| If "YES", provide details |  |  |  |  |
|       |
| Applicant is | For Profit Organization |       | Not for Profit Organization |       |  |
| Applicant is  | a Corporation |       | a Partnership |       | a Sole Proprietor |       |  |
| Incorporation Date (dd/mm/yy) |       |  | Act/Jurisdiction |       |
| If incorporated, a copy of the Letters Patent is required |
| Total Operations Budget for the next twelve (12) months | $ |       |
| Fiscal Year End (dd/mm/yy) |       |  |
| Indicate the Applicant's sources of income and the percentage of total revenue generated from each source |
|       |  |       | % |
|       |  |       | % |
|       |  |       | % |
|  |
| When was the first date on which the Applicant purchased continuous claims made coverage? (dd/mm/yy) |       |
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| **Liability** |  |  |  |  |
| Limit of Liability requested | $ |       |  |  |  |
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| Indicate all professional services provided (including counseling, referral services, legal aid services, medical services or other) |
|       |
|       |
| To whom does the Applicant provide services? |
|       |
|       |
| Indicate all professional association(s) the Applicant belongs to |
|       |
|       |
| Indicate any specific licenses the Applicant is required to have to practice |
|       |
|       |
| Has any disciplinary action been taken against the Applicant or any of the Applicant's employees? | YES |       | NO |       |
| If "YES", provide details |
|       |
| Does the Applicant develop standards used to evaluate the quality of services rendered? | YES |       | NO |       |
| If "YES", provide details |
|       |
| Does the Applicant engage in activities such as lobbying, labour negotiations or have any  |  |  |  |  |
| involvement in the activities and operations of any trade union? | YES |       | NO |       |
| If "YES", provide details |
|       |
| Are all persons required to obtain legal counsel prior to publically commenting on the Applicant's  |  |  |  |  |
| activities? | YES |       | NO |       |
|  |
| **Provide the following information** |
| **Full Name of all Professionals** | **Professional Qualifications** | **Years of Experience** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| What is the source of the board's legal advice? |
|       |
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| **Claims History** |

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| Is the Applicant or any of his/her employees aware of any facts, circumstances or situations which  |  |  |  |  |
| may reasonably give rise to a claim? | YES |       | NO |       |
| If "YES", provide details |
|       |

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| Indicate all claims incurred in the past 5 years (including all payments plus a reserve for outstanding claims) |
| **Year** | **Type of Claim** | **Amount Paid** | **Reserves for Unpaid Claims** |
|       |       | $       | $       |
|       |       | $       | $       |
|       |       | $       | $       |
|       |       | $       | $       |
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| **Applicant Acknowledgement**  |
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| The undersigned authorized officer of the organization declares that, to the best of his/her knowledge, the statements set forth herein |
| are true. Signing of this application does not bind the Insurer to offer, nor the Applicant to accept Insurance, but, it is agreed that this |
| form shall be the basis of the contract should a policy be issued, and this form will be attached to and become part of the policy. |
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|  |
| The undersigned, on behalf of the insured organization, acknowledges that any personal information provided in connection with this |
| application (including but not limited to the information contained in this form) has been collected in accordance with applicable |
| privacy legislation and this information shall only be used or shared by the Company to assess, underwrite and price insurance |
| products and related services, administer and service insurance policies, evaluate and investigate claims, detect and prevent |
| fraud, analyze and audit business results and/or comply with regulatory or legal requirements. |
|  |  |
|  |
| **Applicant Name** |       | **Title/Position** |       |
| **Applicant Signature** |       | **Date** |       |
| **Broker Name** |       |  |  |
| **Broker Signature** |       |  |  |