# LIFE INSURANCE AGENTS PROFESSIONAL LIABILITY *Application*

***NOTICE:*** This is an application for claims made and reported insurance. Such insurance if accepted by the Company, subject to policy provisions, applies only to those claims which are the result of wrongful acts occurring subsequent to the Retroactive Date and which are first made against you and reported to us during the policy term or any applicable Extended Reporting Period. The policy provides that the limit of liability shall be reduced by the amounts paid for legal defense.

**Preferred Risk Characteristics** • Retail agency only cannot insure Managing General Agents/Wholesalers • Have limited claims history • Have $1,000,000 or less in annual commission income. *Please contact us to accommodate higher commission income.*

**1a** Applicant's Name _____ DBA (if applicable) _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (___) _____ Fax (___) _____ Email Address _____

Contact Person _____ Title _____

**1b** Does the applicant own 100% of the listed DBA? ☐ Yes ☐ No ☐ N/A

**1c** Does the applicant own any business entities not listed on the application? ☐ Yes ☐ No

**1d** Please list any additional insureds _____ Additional named insureds _____

**2** Applicant is: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation

**3** Date first licensed: Life/Health* ___/___/___ Series 6 (if applicable) ___/___/___ Series 7 (if applicable) ___/___/___

**If less than three years, provide resumes for each agency principle.*

**4** Please check the professional designations you currently hold:

☐ CLU ☐ RHU ☐ LUTCF ☐ ChFC ☐ CIC ☐ REBC ☐ CPCU ☐ RPLU ☐ Other _____

**5** Does the Applicant function exclusively as a Workplace Marketer/Enroller and derive all their commission income from this activity? ☐ Yes ☐ No

**6** Has the applicant been involved with any mergers, purchases or, acquisitions in the past five years? ☐ Yes ☐ No
*If yes, please describe on a separate sheet.*

**7** Has the applicant ever had any professional license terminated or suspended? ☐ Yes ☐ No

**8** Have any professional liability claims been made against the applicant or any of its past or present owners, officers, partners, employees, or solicitors, or to the knowledge of the applicant on behalf of its predecessors in business, within the last five years?
*If yes, a Supplemental Claim form must be completed and submitted with this application. The Supplemental Claim Information Form is available on the web at* **www.rockwoodinsurance.com** *in the Life Agents E&E section.* ☐ Yes ☐ No

**9** Are there any known circumstances or incidents which may result in a professional liability claim? ☐ Yes ☐ No
*If yes, give details on a separate sheet.*

**10** Declarations of "LICENSED" persons, **(including yourself)**, whether owners, partners, directors, officers, or employees (selling or not).

| A NAME OF LICENSED PERSON | DESIGNATIONS CODE* | COMMISSIONS LAST 12 MONTHS | COMMISSIONS NEXT 12 MONTHS |
|---|---|---|---|
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| **B** Total Number of sub-agents, brokers, and independent contractors _____ | | $ | $ |
| ***Designation Codes:** O = Owner P = Partner OF = Officer/Director E = Employee* ***If neccessary, use a separate sheet.*** | ***Total Commissions:*** | $ | $ |

**C** Unlicensed Staff: Total Number _____ Full Time _____ Part Time _____

***1099 employees are excluded by the policy form, unless added by endorsement. Please note that the policy covers the applicant for any liability resulting from the actions of independent contractors so long as the revenues from independent contractor(s) are indicated above, subject to policy terms and conditions.***

**11** Do you verify that all non-employed sub-agents/independent contractors are required to carry Errors and Omissions coverage? ☐ Yes ☐ No

**12** Please indicate percentages of the applicants revenue derived from each line of business written below: ***The total of all lines should equal* 100%.**

_____ % Life–Individual _____% A&H–Individual _____% Stocks _____% Variable Annuities

_____ % Life–Group _____% A&H–Group _____% Bonds _____% Equity Indexed Annuities

_____ % Fixed Annuities _____% Mutual Funds _____% RIA/Financial Planning _____% All Other *(Describe on a separate sheet)*

*_____ % Pension/Employee Benefit Planning *_____ % Insurance Consulting ***Please provide a brief description on a separate sheet.***

**13a** Does the applicant require coverage for Financial Products (Mutual Funds and Variable Annuities)? ☐ Yes ☐ No
*If Yes, an additional premium will apply.*

**13b** Does the applicant require coverage for Investment Services (Stocks, Bonds, RIA/Financial Planning)? ☐ Yes ☐ No
*If Yes, an additional premium will apply.*

**13c** Do you charge fees for investment services or advice? ☐ Yes ☐ No

**13d** Does the applicant require coverage for incidental Property & Casualty placements? ☐ Yes ☐ No

*If Yes, what is the annual commission income derived from P&C related activity?* $ _____
**NOTE:** Restrictions apply. A supplemental P&C Activities Application must be completed so eligibility can be determined.

**NOTE:** The activities listed in questions 13a and 13b are subject to a sublimit: actions selling variable annuities, mutual funds, stocks bonds; actions as a financial planner/registered investment advisor.

**14** *If Yes to* **13a** *and/or* **13b** *please provide*: Name of Broker Dealer _____

Name of Registered Representative(s) _____

**15 Does the applicant place coverage or have involvement with Self Insured/Captives or Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), Mutiple Employer Trusts (MET), Multiple Employer Welfare Arrangements (MEWA), Stop Loss Products or any self funded or partially funded product?** ☐ Yes ☐ No ***If yes, please provide a brief description of activities in this area (on a separate sheet).***

**16** List the top five Insurance Companies with which you place business:

| Name of Insurance Company | Products Sold | % of Revenues |
|---|---|---|
| | | % |
| | | % |
| | | % |
| | | % |
| | | % |

**17** Do you currently have Errors and Omissions Insurance in Force? ☐ Yes ☐ No

*If yes, what is:* Name of Insurer _____ Expiration Date _____

Retroactive Date _____ Current Limits $ _____ Deductible $ _____ Premium $ _____

Do you wish to purchase prior acts coverage? ☐ Yes ☐ No
***NOTE:*** *Prior Acts coverage may only be available if the applicant has had continuous coverage in force with no gaps. If the applicant has not carried coverage or is not able to provide proof of coverage, the retroactive date of the policy will be inception. If "Yes", proof of prior coverage will be required.*

**18** Limits of liability desired $ _____ Deductible amount desired $ _____

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY. SUCH POLICY MAY BE CANCELLED BY THE COMPANY FROM INCEPTION UPON DISCOVERY THAT THE POLICY WAS OBTAINED THROUGH FRAUDULENT STATEMENT, OMISSION, OR CONCEALMENT OF THE FACTS MATERIAL TO THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED BY THE COMPANY.

**THE APPLICANT REPRESENTS THAT THE STATEMENTS AND RESPONSES TO THE QUESTIONS ON THIS APPLICATION ARE ACCURATE AND COMPLETE. APPLICANT ALSO WARRANTS THAT SUCH STATEMENTS AND RESPONSES ARE TRUE, CONTAIN NO MISREPRESENTATIONS AND THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION OR ATTACHMENTS THERETO CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES.**

Signature _____ Date _____
*(Must be signed by an owner or officer of the applicant)*

Please Print Name _____ Title _____

***Referred by:***
Agent Name _____ E-mail _____ Tel ( _____ ) _____