



**APPLICATION FOR
INSURANCE AGENTS AND BROKERS
PROFESSIONAL LIABILITY INSURANCE**



4001 Miller Road, Wilmington, DE 19802-1999 • Ph: 877-764-4555 • Fax: 302-765-2088 • Web: www.rockwoodinsurance.com

THIS APPLICATION IS FOR A CLAIMS MADE AND REPORTED POLICY.

- **This application must be completed in full, including all required attachments**
- **Attach a separate sheet of paper if more space is needed to answer any question.**
- **We treat all applications as confidential.**

1. Named Insured: _____

DBA (if any): _____

Home Office Mailing Address: _____

Physical Address _____

Phone: () _____ FAX: () _____ EMAIL: _____

Additional Locations: _____

2. Date Business Established: _____

If in operation less than three (3) years, please attach license(s) and resume(s) for all principals.

Form of Organization:

- Corporation
 Partnership
 Other: _____

Is the applicant firm controlled, owned (in whole or part), affiliated or associated with any other firm, corporation, company or entity? Yes No

If Yes, please explain relationship: _____

3. During the past 5 years:

a). Has the name of the firm been changed, or has any business/firm been acquired, merged into, consolidated or sold off by/from the original firm? Yes No

If Yes, please explain and provide name (s) of predecessor firm(s) _____

b) Has there been a change in management structure, including any additions, or deletions of any principals, owners, managers or brokers? Yes No

If Yes, please explain: _____

c) Have there been any cluster arrangements? Yes No

If Yes, please explain: _____

4. a). List the current top five (5) insurance companies for whom you produce premium.

Insurance Company Name	Years Represented	Annual Premium Volume	Current A.M. Best Rating
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

b). What percent of business is placed with: Admitted Carriers: ____% Non-Admitted Carriers ____%

5. a). List ALL insurance companies, currently rated NR or B+ or less by A.M. Best for which you placed business over the last three (3) years.

Insurance Company Name	Years Represented	Annual Premium Volume	Current A.M. Best Rating
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

b). List all insurance carriers with whom agency contracts have been terminated in the last 5 years and provide a reason for each termination. (If none, state "none"). _____

6.

		Previous 36 Months	Previous 24 Months	Current 12 Months	Estimated Next 12 Months
a).	Total P&C gross written annual premium:				
b).	Total gross annual P&C commissions:				
c).	Total Life and A&H gross written premium:				
d).	Total gross annual Life and A&H commissions:				
e).	Total annual income derived from other insurance related activities:				

7. a). Written business by Premium Volume: (**MUST** total Current 12 Months figure amount indicated in Question 6).

COMMERCIAL LINES		PERSONAL LINES	
CMP/Package	\$	Auto—Standard	\$
CGL/BOP	\$	Auto—Non-Standard	\$
Umbrella/Excess	\$	Homeowners	\$
Auto—Standard	\$	Non-Standard Fire	\$
Auto—Non-Standard	\$	Pleasure Boats	\$
Long Haul Trucking	\$	Mobile Homes/RVs	\$
Workers Compensation	\$	Motorcycles	\$
Livestock Mortality	\$	Wind/Flood/EQ	\$
Crop Coverages	\$	Umbrella	\$
Medical Malpractice	\$	Other (Specify)	\$
Professional Liability—(Specify)	\$	TOTAL PERSONAL LINE	\$
Wet Marine	\$		
Inland Marine	\$	LIFE AND A&H INSURANCE	
Bonds/Surety	\$	Life, Individual	\$
Aviation	\$	Life, Group	\$
Products Liability	\$	A&H, Individual	\$
Other (Specify)	\$	A&H, Group	\$
TOTAL COMMERCIAL LINES	\$	Annuities	\$
		HMO/PPO/DSP	\$
		Other (Specify)	\$
		TOTAL LIFE and A&H	\$

b). Property and Casualty Business Placed As:

Agent (business placed directly with carriers)	%
Broker/Wholesaler	%
Managing General Agent/Underwriter	%
Reinsurance Intermediary	%
Surplus Lines Broker	TOTAL 100 %

*If ANY business is placed as an MGA or MGU, please complete and attach the **Managing General Agent/Underwriter Supplemental Application**.*

c). Percentage of policies written on a direct bill basis: _____ %

d). Percentage of gross written premium placed through a service center: _____ %

e). Percentage of gross written premium placed through a state administered fund: _____ %

f). Percentage of business written through MGA's, other brokers or intermediaries: _____ %

8. a). Do you place mutual funds through a securities broker/dealer that is affiliated with an insurance company? Yes No

If mutual funds coverage is desired, complete the following:

Broker/Dealer	Insurance Company	Licensed Agent	Income	Series License Type
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

b). **If investment or securities products coverage is desired, complete the following:**

Desired sublimit: \$250,000 \$500,000 \$1,000,000 \$2,000,000

Broker/Dealer	Insurance Company	Licensed Agent	Income	Series License Type
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

9. Does the Applicant perform any of the following activities? If yes, attach resume (s), promotional materials and sample contract(s).

Revenue/Income

- a). Reinsurance Intermediary Yes No \$ _____
- b). Third Party Administrator Yes No \$ _____
- c). Claims Adjustment Services Yes No \$ _____
- d). Investment/Securities Advisor Yes No \$ _____
- e). Actuarial Services Yes No \$ _____
- f). Legal Adviser/Services Yes No \$ _____
- g). Tax Adviser Yes No \$ _____
- h). Risk Management/Loss Control Yes No \$ _____
- i). Title Insurance Yes No \$ _____

If Yes is indicated for b or c, a Third Party Administration and Claims Administrative Services Supplemental Application MUST be completed and attached to this Application.

10. In the past five (5) years, has the Applicant:

- a). Specialized in any programs or classes of business? Yes No
- b). Placed coverage or been involved in Self Insured/Captives, Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), or Multiple Employer Trusts (MET)? Yes No

If either of the above are answered Yes, please attach an explanation, including the name of the program(s), carrier(s), extent of coverage(s) provided, administrative duties performed by the Applicant, and any applicable financial information.

11. Please indicate the number of:

Owners, Officers, Partners _____ Exclusive Non-Employee Producers _____
 Employed Solicitors, Brokers, Agents _____ Non-Exclusive Non-Employee Producers _____
 All Other employees _____

List all agency owners, officers and licensed producers:

Name	Position/Title	License No.	No. of Years Licensed with Applicant
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Office Controls and Procedures:

- a). Does the Applicant have a Home Page and/or Web Site? www._____ Yes No
 If Yes, is it used for Marketing? Yes No
 If Yes, is it used for Sales? Yes No
 Are applications completed/submitted/bound through the Internet? Yes No
- b). Does Applicant utilize a computerized accounting, billing and production system? Yes No
- c). Is it standard office procedure to:
 - Date stamp incoming mail? Yes No
 - Document all telephone conversations? Yes No
 - Maintain a policy expiration list? Yes No
 - Check all applications, policies and endorsements for accuracy? Yes No
 - Maintain a diary/suspense system? Yes No
- d). Please describe the procedures/manual documentation used to ensure the above procedures are implemented. _____

- e). Does the Applicant have a specific orientation program/office manual review for all new employees? Yes No

13. Is there any entity(s) having a 10% or greater interest in the Applicant, any subsidiary and/or affiliate of the Applicant? Yes No
 If Yes, please provide the entity's name, % ownership interest and relationship to Applicant.

14. a). Has any prospective insured, or any of its employees, ever been subject to an investigation by a state regulatory agency, administrative agency and/or an insurance department investigation or inquiry or disciplinary investigation or proceeding in any way? Yes No
 If Yes, please provide an explanation. _____

b). Has any prospective insured, or any of its employees, ever had their license revoked, suspended, or been fined or disciplined by any state or regulatory department? Yes No
 If Yes, please provide an explanation. _____

15. Has any policy or application for Errors and Omission insurance on behalf of the Applicant, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors ever been declined, cancelled or renewal refused within in the last five (5) years? Yes No

If Yes, please provide an explanation. _____

16. During the past five (5) years, has any claim or notice of claim been made or suit brought against the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors? Yes No

If Yes, A CLAIM SUPPLEMENTAL APPLICATION MUST BE COMPLETED AND ATTACHED.

IT IS UNDERSTOOD AND AGREED THAT, WITHOUT LIMITING ANY RIGHTS OF THE UNDERWRITER, IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED INSURANCE.

Is the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors aware of any fact, circumstance, situation, allegation, contention or incident which may result in a claim being made against the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors? Yes No

If Yes, A CLAIM SUPPLEMENTAL APPLICATION MUST BE COMPLETED AND ATTACHED.

IT IS UNDERSTOOD AND AGREED THAT, WITHOUT LIMITING ANY RIGHTS OF THE UNDERWRITER, IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED INSURANCE.

17. List Errors and Omissions carriers/information for the last 3 years. (If none, state "none").

	Name of Carrier	Policy Period	Limits of Liability	Deductible	Premium	Retro Date
a).	_____	_____	\$_____/ \$_____	\$_____	\$_____	_____
b).	_____	_____	\$_____/ \$_____	\$_____	\$_____	_____
c).	_____	_____	\$_____/ \$_____	\$_____	\$_____	_____

THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY ROCKWOOD IN WRITING OF SUCH CHANGES. ROCKWOOD RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS/ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH HEREIN AND ATTACHED HERETO ARE TRUE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION,

INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE UNDERWRITER ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE UNDERWRITER.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: 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, WHICH IS A CRIME.

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 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.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND 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 MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND 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 MARYLAND APPLICANTS: 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 MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY 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 SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: 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 OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

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.

A POLICY CANNOT BE ISSUED UNLESS THIS APPLICATION IS PROPERLY SIGNED AND DATED.

Signature of Applicant: _____
(MUST be signed by an Owner, Partner, Director, or Officer of the Named Insured.
It is agreed the signer has authority to act on behalf of all insureds.)

Printed Name of Applicant: _____ Title _____

Date: _____



**SUPPLEMENTAL APPLICATION FOR
MANAGING GENERAL
AGENT/UNDERWRITER**



4001 Miller Road, Wilmington, DE 19802 • Ph: 877-764-4555 • Fax: 302-765-2088 • Web: www.rockwoodinsurance.com

NOTE: Please attach a sample contract of engagement.

1. Named Insured _____
 DBA (if any) _____
 Home Office _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Physical Address _____
 City _____ State _____ Zip _____
 Phone (____) _____ Fax (____) _____ Email _____
 Additional Locations _____

2. a) List ALL carriers for whom you are an MGA, MGU or Program Administrator:

Name of Carrier	Lines of Insurance		No. of Years
Annual Gross Written Premium	Loss Ratio (Percent) Each of the Last 3 Years		
\$	%	%	%
\$	%	%	%
\$	%	%	%
\$	%	%	%

b) Please describe any industries in which you specialize: _____

3. Please describe ALL functions you perform as an MGA, MGU and/or Program Administrator.

4. List and describe the circumstances behind all insurance carriers who MGA/MGU and/or Program Administrator contracts have been terminated in the last 5 years.

5. During the last two (2) years, have you:

- a) Written business directly with the International Insurance Company of Hannover (Inter-Hannover)? Yes No
- b) Made a direct reinsurance placement with Hannover Re? Yes No

6. Please indicate:

- a) Number of policies issued annually . . . _____
- b) Maximum limits of liability you are able to issue, by line(s) of business. . . . _____
- c) Number of producers from whom you accept business _____
- d) Number of producers/agents with binding authority _____
- e) Number of audits performed by carrier(s) annually _____
- f) Does the Applicant have a specific orientation program/office manual review for all new employees? Yes No

7. Please describe the procedures/manual documentation used to ensure the adherence to Carrier procedures:

8. a) In the last three years, has any audit by an insurer stated that the Applicant:

- Had exceeded its premium cap or underwriting authority? Yes No
- Did not issue the correct policy wording and/or endorsements as mandated by the insurer? Yes No
- *If the response to either of the above questions is "Yes", provide details and actions taken to amend procedures:*

b) In the last three years, other than minor infractions, were all audits by insurers satisfactory? Yes No

If No, provide details: _____

9. Do your MGA Agreements contain provisions requiring that you indemnify your Carrier for losses? . . Yes No

If "Yes", is the indemnity provision:

- a. Based on the losses sustained by your Carrier directly from your conduct? Yes No
- b. Is there a mutual obligation for your Carrier to indemnify you for losses sustained due to your carrier's conduct? Yes No
- c. Does the indemnity provision require that you defend you Carrier? Yes No

It is hereby understood and agreed this Managing General Agent/Underwriter Supplemental Application, and required attachment(s) becomes part of and is deemed attached to the **INSURANCE AGENTS AND BROKERS PROFESSIONAL LIABILITY INSURANCE POLICY APPLICATION.**

Signature of Applicant: _____
 (MUST be signed by an Owner, Partner, Director, or Officer of the Named Insured.
 It is agreed the signer has authority to act on behalf of all insureds.)

By checking this box, the signatory warrants that the Application has been completed in its entirety by an Owner, Director, or Officer of the Named Insured. **NOTE: This confirmation must be provided in order for Rockwood to consider the Application completed.**

Printed Name of Applicant _____ Title _____

Date _____