

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

Rockwood Programs, Inc.
3001 Philadelphia Pike, Claymont, DE 19703
Tel: 305-248-9495 • Fax: 305-248-9496
Website: www.rockwoodinsurance.com



1. Name of Applicant: _____ Requested Effective Date: _____
DBA: _____
(If applicable, include DBA or Trade Name)

A. Number of years in business under the above name: _____

B. Do you conduct Operations under any other Names? Yes No If yes, please list these Names on a separate page.

2. Mailing Address: _____
(Street) (City) (State) (Zip Code)

Physical Address: _____
(Street) (City) (State) (Zip Code)

Physical Address: _____
(Street) (City) (State) (Zip Code)

A. Do you have any other Physical Locations? Yes No If yes, please list these Addresses on a separate page.

3. Contact Name: _____

4. Phone: _____ Email: _____

Fax: _____ Website: _____

5. Business Type: Individual Partnership LLC Corporation Other (Describe): _____

6. States in which the Agency/Brokerage is Licensed: _____

7. Have you been involved in any acquisitions or mergers within the last 5 years? Yes No

A. If yes, please provide details: _____

8. Please provide the following information about your current Errors and Omissions (E&O) Liability Insurance:

A. Expiring Carrier Name: _____

Expiring Policy Term: _____ Expiring Retroactive Date: _____

Expiring Each Claim: \$ _____ Expiring Aggregate Limit: \$ _____

Expiring Deductible: \$ _____ Expiring Premium: \$ _____

B. How many years have you had continuous E&O Liability Insurance in place (i.e. w/o a gap in coverage)? _____

C. Has there been an interruption in your Retroactive Date? If yes, please explain below. Yes No

9. Provide the name of each Carrier with whom you currently place business and your corresponding total annual Gross Written Premium. In addition, indicate if the Carrier is an Admitted Carrier and if you can access the Carrier on a Direct basis.

Carrier Name	Annual Gross Written Premium	Admitted?	Direct Appointment?
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. Is any of your business currently placed with a Carrier that has an AM Best Rating of B+ or lower? Yes No

If yes, please answer A-C.

A. What is the name of this Carrier and what is their rating? _____

B. What percentage of your total annual Gross Written Premium is placed with this Carrier? _____ %

C. Is this Carrier guaranteed or operated by a Governmental body? Yes No

11. Within the last 3 years, have you lost 2 or more Carrier appointments? Yes No

A. If yes, please explain: _____

12. Within the last 3 years, has your total annual Gross Written Premium increased or decreased more than 50%? Yes No

13. Provide your current total annual Gross Written Premium: \$ _____

14. Provide a breakdown of your total annual Gross Written Premium (must total 100%).

Personal Lines	Percentage	Commercial Lines	Percentage
Auto - Non-standard and Motorcycles	%	Animal Mortality	%
Auto - Standard	%	Auto - Non-standard	%
Flood	%	Auto - Standard	%
Homeowners	%	Aviation	%
Pleasure Boats and/or Wet Marine	%	Bonds	%
Umbrella	%	BOP, General Liability and/or Property	%
Other (Describe):	%	Crop	%
Life, Accident and Health	Percentage	Excess and/or Umbrella	%
Group Accident and Health	%	Flood	%
Group Life	%	Inland Marine	%
Individual Accident and Health	%	Long Haul Trucking	%
Individual Life	%	Medical Malpractice and/or Professional Liability	%
Other Financial Products (i.e. requiring a Series 6 or 7 License)	%	Ocean Marine	%
		Workers Compensation	%

15. Provide the Name and Ownership Percentage for each Owner as well as the corresponding Licensing and Experience information.

Business Owner(s) Name	Percentage(s) of Ownership	Licensed Agent/Broker?	Number of Years of Agency Management Experience
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	%	<input type="checkbox"/> Yes <input type="checkbox"/> No	

16. Are the Owner(s) active in the daily business activities of the Agency (i.e. as an on-site Manager)? Yes No

17. Agency/Brokerage staffing - please provide the total number of:

A. Owners: _____ Full-time Employees: _____ Part-time Employees: _____

B. Producers: _____ Non-Employee Producers (i.e. that are paid on a 1099): _____ CSRs: _____

C. Employees with at least 3 years of Insurance experience: _____

D. Employees holding a professional designation (e.g., RPLU, ASLI, CRM, ARM, CPCU, CIC, CLU, CISR): _____

E. Employees who have attended an Errors and Omissions Loss Prevention Seminar within the last 2 years: _____

18. Do your operations include any non-Insurance related sales or services? If yes, indicate all that apply below. Yes No

Accounting Financial Planning/Advising Legal Real Estate Travel Agent Other (Describe below)

19. Do you adjust claims or make claim determinations? Yes No

If yes, please answer A-B.

A. What type of claims? Liability Property Physical Damage Other (Describe): _____

B. What is your claim adjustment/determination authority? \$ _____

20. Do you act as a Third Party Claims Administrator? Yes No

21. Do you provide Captive Feasibility or Captive Management services? Yes No

22. Do you provide Fee Consulting? Yes No

A. If yes, do these operations represent more than 20% of your total annual Gross Written Premium? Yes No

23. Do you have any Association endorsed or supported Programs? Yes No

A. If yes, how many Policies do you have written in that Program? _____

24. Do you operate as an MGA, General Agent or Wholesaler? Yes No

25. Do you have any non-contracted Producers or Independent Contractors? Yes No

A. If yes, please explain: _____

26. Do you delegate binding authority to anyone other than qualified members of your Staff? Yes No
A. If yes, please explain: _____
27. Which Agency Management system do you use? _____
28. Do you maintain:
A. Procedural guidelines, including authority levels, for all members of your Staff? Yes No
B. Suspense and renewal lists for all Policies? Yes No
C. Complete and updated notes in all Policy files? Yes No
D. Loss notices and follow-ups? Yes No
29. Do you have emergency or disaster management procedures in place, including off-site data back-up? Yes No
30. Do you conduct E-commerce? Yes No
If yes, please answer A-E.
A. Do you have Cyber Liability coverage (i.e. including Data Breach) in place? Yes No
B. Do you have a written corporate privacy policy? Yes No
C. Do you have a written incident response plan? Yes No
D. Does your system have disclaimers? Yes No
E. Are all payments processed through a third party? Yes No
31. Are you currently, or have you ever been, the subject of any regulatory or disciplinary action or investigation? Yes No
A. If yes, please explain: _____

32. Are you currently, or have you ever been, in bankruptcy or receivership proceedings? Yes No
A. If yes, please explain: _____

33. Within the last 5 years, have any claims, suits or proceedings been made against you, your firm, your predecessors in business or against any present Partners, Owners, Officers, Managers or Employees? Yes No
A. If yes, please explain: _____

34. Are you aware of any alleged act, circumstance, situation or error or omission which may result in a claim being made against you or any of the persons or businesses described in this application? Yes No
A. If yes, please explain: _____

35. Within the last 5 years, has your Errors and Omissions Liability Insurance been Declined, Cancelled or Non-renewed? Yes No
A. If yes, please explain: _____

ANY POLICY QUOTED MAY BE SUBJECT TO A MINIMUM POLICY PREMIUM.

FRAUD WARNING: 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 IS GUILTY OF INSURANCE FRAUD. THIS IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (FOR NEW YORK INSUREDS: AN ACT OF INSURANCE FRAUD SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

YOU HEREBY DECLARE that the above statements and particulars are true and that you have not suppressed or misstated any material facts and you agree that this Application will be the sole basis of any subsequent contract or insurance with us. Signature on the Application does not bind you or us to complete the insurance.

Application must be signed and dated by Principal, Partner, Officer or Director of the business.

Applicant's Signature:		Date:	
Applicant's Name:		Applicant's Title:	

PLEASE NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTATION ONLY. NO COVERAGE WILL BE EFFECTED UNTIL RECEIPT OF WRITTEN INSTRUCTIONS AND PREMIUM PAYMENT. ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION AND THIS APPLICATION WILL BE MADE A PART OF THE COVERAGE FORM. A SIGNED APPLICATION DATED NOT MORE THAN 45 DAYS PRIOR TO THE INCEPTION DATE WILL BE REQUIRED IN THE EVENT COVERAGE IS EFFECTED.