

**Professional Liability Insurance for Pension Professionals
New Business Application**

CLAIMS MADE WARNING FOR APPLICATION. THIS APPLICATION FORM IS FOR A CLAIMS MADE POLICY RELATING TO CLAIMS MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD THAT MAY APPLY. PLEASE READ THE POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, COVERAGE AND COVERAGE RESTRICTIONS.

1. Name of applicant: _____

Individual Partnership Corporation Other _____

Primary Location Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address if Different than Physical Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Website Address: _____ Email Address: _____

2. Date firm was established: _____

3. Has the name of this firm changed within the past five years? Yes No

If yes, indicate change and why change occurred:

4. Has the applicant been involved in any mergers, purchases, acquisitions or sales of all or part of your business within the past five years? Yes No

If yes, please provide a detailed explanation to include the date of the change; type of acquisition (assets only or assets and liabilities); names of an other entities involved, etc.

5. Please list all subsidiaries and/or branch offices and addresses.

12. List revenue from services provided.

Services Provided	Gross Revenues for Last Year	Gross Revenues for Current Year	Projected Gross Revenues for Next Year
Administrative and Actuarial Consulting	\$ _____	\$ _____	\$ _____
Insurance Sales	\$ _____	\$ _____	\$ _____
401(k) and Mutual Fund Sales and Servicing	\$ _____	\$ _____	\$ _____
Investment Consulting for a Fee or Commission	\$ _____	\$ _____	\$ _____
Other (describe)	_____	_____	_____
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____

13. Indicate the approximate number of plans and the approximate revenue generated by these plans for the following categories of clients.

Category	Number of Plans	Revenue for Last Year	Revenue for Current Year	Projected Revenue for Next Year
Unions	_____	\$ _____	\$ _____	\$ _____
Attorney/Law Firms	_____	\$ _____	\$ _____	\$ _____
Physician/Physician Groups/Dentists	_____	\$ _____	\$ _____	\$ _____

14. Briefly describe your three largest clients in the past year by fee income:

Nature of services provided	Revenues
_____	_____
_____	_____
_____	_____

15. Do you conduct any business activities outside of the USA where any OFAC Economic and Trade Sanctions or any other Regulations are currently in place? Yes No

If yes, please state the place and the nature of this business.

16. Have you received the CEFEX ASPPA Administration Services Certification? Yes No

17. Do you utilize the PensionPro Workflow Systems software? Yes No

18. Do you utilize subcontractors? Yes No

If so, what percentage of your gross receipts is paid to subcontractors?
Describe the type of work subcontractors perform.

19. Has the applicant ever done any work in connection with a benefit plan or other transaction that is the same or substantially similar to a transaction that has been identified by the IRS as a "listed transaction" or "transaction of interest"? Yes No

If yes, please provide a detailed explanation to include the dates of your work on such transactions, the nature of services your provided and the parties involved. Attach a separate page if necessary.

If no, please confirm that you have reviewed the complete list of IRS "listed transactions" and "transactions of Interest" at the IRS website within the last six months. Confirmed Did Not Confirm

20. Do you use a system for the transfer of funds, currency and or other assets that includes established rules, policies and procedures that require at least two, separate forms of authenticating the requests and instructions for such transfers? Yes No

If no, please explain what procedures you have in place to verify all transfers?

21. Do you use a dual-control accounting system? Yes No

If no, please explain what procedures you have in place to prevent embezzlement and misdirected funds.

22. Are you administering or have you administered any plan that is or was at any time underfunded or that was claimed or suggested by anyone to be underfunded? Yes No

If yes:

What percentage of your overall administered plans are underfunded? _____ %

By how much (total) are these plans underfunded? \$ _____

23. Do you adjust fees to settle minor error and/or omissions? Yes No

If yes, please explain.

24. Do you use a written contract? Yes No

If yes, are contracts updated and resigned every year? Yes No

If no, how do you define your responsibilities to your customers?

25. Do you sell variable annuities? Yes No

If yes, do you have your customers sign off saying that they understand the nature of these annuities?
 Yes No

26. Please provide the following information for similar insurance, if any, carried during the last three years.

Policy Term	Company	Limits	Deductible	Premium
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
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27. Original date from which have carried UNINTERRUPTED professional liability coverage with any carrier.

NOTE: This date determines the retroactive date on your policy. EXAMPLE: If you first purchased professional liability insurance on June 1, 1982 and have continuously renewed coverage each year, you would answer this question June 1, 1982.

28. Does any person to be insured have knowledge or information of any act, error omission (including fee disputes) which might reasonably be expected to give rise to a claim? ("Claim" shall mean a demand received by the insured for money or services, including service of suit or institution of arbitration proceedings against the insured.)
Yes No

If yes, please provide a full explanation.

29. Have any of the individuals listed in question 12 ever been the subject of disciplinary action by authorities as a result of the professional activities? Yes No

If yes, please explain.

30. Please advise status of all professional liability claims against any proposed insured(s) during the past five years.
If none, please check here: None

If there are claims, please complete the Claim/Incident Supplemental Form for each claim during the past five years.

If is agreed with respect to questions 28, 29 and 30 above, that if such knowledge or information exists any claim or action arising therefrom is excluded from this proposed coverage.

PLEASE READ CAREFULLY: THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND MADE PART OF THE POLICY. THE UNDERSIGNED APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND AFTER INQUIRY OF ALL PEOPLE LISTED IN QUESTION NINE, THE STATEMENTS SET FORTH IN THE APPLICATION ARE TRUE. THE APPLICANT FURTHER DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE TIME WHEN THE POLICY IS ISSUED, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGE.

Applicant's Signature: _____ Title: _____
(Owner, Partner or Senior Officer)
Printed Name: _____ Date: _____

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

NOTICE TO ALL 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, NOW OR AT ANY TIME, COMMITS A FRADULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Notice to Rhode Island Customers: This Insurance contract has been placed with an insurer not licensed to do business in the state of Rhode Island but is approved as a surplus lines insurer. The insurer is not a member of the Rhode Island insurers insolvency fund. Should the insurer become insolvent, the protection and benefits of the Rhode Island insurers insolvency fund are not available.

Notice to Wyoming Customers: The insurer with which the surplus lines broker places the insurance is not licensed by this state and it not subject to its supervision. In the event of the insolvency of the surplus lines insurer, losses will not be paid by the state insurance guaranty association.

Professional Liability Insurance for Pension Professionals Claim/Incident Supplemental Form

Complete one form for each claim or circumstance during the last 5 years. If space is insufficient to answer any questions fully, provide separate attachments.

1. Name of applicant: _____
2. Full name of individuals involved in the claim: _____
3. Full name of claimant: _____
4. Date of alleged error: _____ Date of claim: _____
5. Has this claim, suit or circumstance been reported to any insurance carrier? Yes No
If yes, date reported to the insurance carrier? _____
6. Name of insurance company the claim, suit or circumstance reported to: _____
7. Claim status: Closed Open In Suit Potential
8. If paid:
 - a. Amount of damages paid: _____
 - b. Amount of expenses paid: _____
9. If open or in suit:
 - a. Total damages demanded: _____
 - b. Total expenses paid to date: _____
 - c. E&O carrier loss reserve: _____ **IMPORTANT**
10. Act, error or omission alleged by claimant:

11. Description of claim and events:

12. What policies and/or procedures have been implemented or revised to prevent a recurrence of a similar claim, suit or circumstance?

The statements included on this page are true and correct to the best of my knowledge.

Applicant's Signature: _____ Title: _____
(Owner, Partner or Senior Officer)

Printed Name: _____ Date: _____

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