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APPLICATION – BROKERS ERRORS AND OMISSIONS PROFESSIONAL LIABILITY INSURANCE

New Application Renewal Application

If it is a renewal, provide Policy Number _____ Expiration date _____

1. FULL NAME OF THE APPLICANT (if more than one, show principal applicant **only**, and additional applicants below):

Additional applicants (to be named insureds)

Name	Activities
_____	_____
_____	_____
_____	_____

2. HEAD OFFICE ADDRESS:

Date Established: _____ Month _____ Year _____

Phone: _____ Fax: _____

Website: _____

Contact Email: _____

Location(s) of Branch offices: _____

3. HAS THE NAME OF THE BROKERAGE, OWNERSHIP OR PRINCIPALS OF THE BROKERAGE CHANGED, OR HAS ANY OTHER BUSINESS BEEN PURCHASED, MERGED OR CONSOLIDATED WITH THE BROKERAGE, INCLUDING THE PURCHASE OF ANOTHER BROKER'S BUSINESS, DURING THE PAST FIVE YEARS?

Yes No If "Yes" please list details below including gross income derived from other business.

4. IS THE BROKERAGE ENGAGED IN ANY OTHER BUSINESS? Yes No

If "Yes" please provide details:

5. IS THE BROKERAGE OWNED BY, ASSOCIATED WITH OR CONTROLLED BY ANY OTHER BUSINESS(ES)? Yes No

If "Yes"; please provide name, percentage of ownership, description of business of parent or controlling interest, kind and amount of insurance derived from associated businesses or owner.

6. A) TOTAL GROSS P&C PREMIUMS WRITTEN ANNUALLY \$ _____

B) TOTAL LIFE, ACCIDENT & HEALTH COMMISSIONS WRITTEN ANNUALLY \$ _____

7. WHAT PERCENTAGE OF TOTAL INCOME COMES FROM:

Insurance _____%

Claim Settlement for a fee _____%

Premium Financing

For own clients _____%

For others _____%

Consulting for a fee _____%

Third Party Administration for

Employee Benefit / Pension Plan _____%

Other (Specify) _____%

(MUST TOTAL 100%)

8. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL PREMIUM VOLUME.

Business placed as:

_____ % Broker (with binding authority)	_____ % MGA* (with binding authority)
_____ % Broker (without binding authority).	_____ % MGA* (without binding authority)
100% TOTAL	

*(MGA / Managing General Agency: agency operating with a broad grant of authority by an insurance company or Lloyd's to underwrite, bind and issue policies.)

9. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL PREMIUM VOLUME:

Business received or assumed:

_____ % Direct from insureds
_____ % From other brokers
100% TOTAL

10. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL P&C PREMIUM VOLUME.

_____ % Personal Lines
_____ % Commercial Lines
100% TOTAL

11. PLEASE GIVE THE APPROXIMATE PERCENTAGE BREAKDOWN OF THE TOTAL P&C PREMIUM VOLUME:

Classes of Business:

Animal mortality	_____ %
Automobile:	
Long Haul Trucking (50 miles radius and greater)	_____ %
Commercial (All other)	_____ %
Personal	_____ %
Aviation	_____ %
Bonds:	
Surety / contract	_____ %
Other bonds	_____ %
Crop Insurance	_____ %
General Property / Casualty	_____ %
Inland Marine	_____ %
Professional Liability	_____ %
Wet Marine:	
Commercial	_____ %
Pleasure	_____ %
Other (Specify)	_____ %
TOTAL	100%

12. IS THE BROKERAGE ASSOCIATED WITH A CLUSTER OR SIMILAR TYPE ARRANGEMENT?

Yes No If Yes, please provide details.

13. DOES ANYONE FROM THE BROKERAGE SIT ON ANY COMPANY BOARD OF DIRECTORS OR GOVERNING COMMITTEES INVOLVING AN INSURANCE RELATED ACTIVITY?

Yes No If Yes, please provide details.

14. PLEASE LIST THE INSURANCE COMPANIES WHICH TOGETHER ACCOUNT FOR 100% OF YOUR TOTAL PREMIUM VOLUME AND INDICATE IF YOU HAVE BINDING AUTHORITY. PLEASE INCLUDE ALL INSURERS USED VIA AN INTERMEDIARY.

(It is not sufficient to show just the name of the intermediary)

COMPANY	%	BINDING? YES/NO	DO YOU HAVE DIRECT ACCESS? (YES/NO) (If No, give name of intermediary)
	%		
	%		
	%		
	%		
	%		
	%		

15. PLEASE LIST ANY UNLICENSED OR NON-ADMITTED INSURANCE COMPANIES THAT YOU PLACE BUSINESS WITH.

COMPANY	%	BINDING? YES/NO	DO YOU HAVE DIRECT ACCESS? (YES/NO) (If No, give name of intermediary)
	%		
	%		
	%		
	%		
	%		
	%		

16. PLEASE INDICATE THE BROKER'S E&O CARRIER FOR THE LAST THREE YEARS. If none, state none.

CARRIER	POLICY NUMBER	LIMIT	EFFECTIVE AND EXPIRATION DATE	CURRENT PREMIUM (OPTIONAL)
		\$		\$
		\$		\$
		\$		\$
		\$		\$

17. IF YOU HAVE NOT HAD ERRORS AND OMISSIONS COVERAGE FOR THE LAST (3) YEARS OR HAVE HAD A GAP IN COVERAGE, PLEASE GIVE US A NARRATIVE EXPLANATION.

18. PLEASE GIVE INFORMATION REQUESTED FOR ALL BROKER STAFF. Over 20 hours is counted as full time.

	NAME	LICENSED? YES/NO	PROFESSIONAL DESIGNATION	POSITION	FULL TIME OR PART TIME?
a) Licensed Owners, Partners, Officers, Directors:					
b) Licensed producers who are employees of the brokerage:					
c) All other employees including non licensed owners, partners, officers and directors:					
SUB-TOTAL OF FULL AND PART - TIME EMPLOYEES (a + b + c) _____					
d) Operational Coverage producers, office brokers who are not employees of the Brokerage and are to be named as Additional Insureds					
SUB-TOTAL TO BE NAMED AS ADDITIONAL INSUREDS (18. d) _____					

e) If more than one office, please indicate the total number of staff members at each location.

Location # 1 _____ # 2 _____ # 3 _____ (Total of all to be included above and below.)

If more locations, attach sheet with information on staff members at each location.

TOTAL STAFF _____

f) Do any of the persons listed in a) to e) above work for any other brokerage or for themselves? Yes No

If Yes, please provide details.

19. DID ANY OF YOUR EMPLOYEES PARTICIPATE IN AN ERRORS AND OMISSIONS PREVENTION SEMINAR DURING THE PAST 24 MONTHS? Yes No

If "Yes", please provide details including date, number of staff, and sponsor of program.

20. PLEASE DESCRIBE THE DETAILS OF TRAINING SESSIONS OR COURSES PROVIDED OR TAKEN:

21. PLEASE DESCRIBE YOUR ORIENTATION PROGRAM FOR NEW EMPLOYEES:

22. IS ALL INCOMING MAIL DATE STAMPED? Yes No

23. ARE VERBAL BINDERS CONFIRMED IN WRITING? Yes No

24. ARE COPIES OF BINDERS MAILED TO BOTH INSURED AND INSURANCE CARRIER WITHIN THREE (3) DAYS? Yes No

25. IS THERE A PROCEDURE FOR DOCUMENTING IMPORTANT PHONE CONVERSATIONS? Yes No

26. IS A POLICY EXPIRATION LIST MAINTAINED? Yes No

27. ARE ALL POLICIES AND ENDORSEMENTS CHECKED FOR ACCURACY BEFORE MAILING? Yes No

28. PLEASE DESCRIBE THE LEVELS OF AUTOMATION WITHIN YOUR BROKERAGE:

29. DOES THE APPLICANT HAVE A PLANNED DIARY, SUSPENSE OR FOLLOW-UP SYSTEM?

Yes No If "Yes": please describe.

30. DOES THE APPLICANT HAVE A FORMAL TRAINING/COMPLIANCE MANUAL ALONG WITH A DESIGNATED PERSON RESPONSIBLE FOR THE MAINTENANCE OF THE MANUAL?

Yes No If No, please comment.

31. DOES THE APPLICANT HAVE A WRITTEN PROCEDURE THAT HAS BEEN COMMUNICATED TO ALL PERSONS ENGAGED BY THE APPLICANT THAT DETAILS THE PROCEDURE FOR THE HANDLING OF COMPLAINTS AND/OR THE NOTIFICATION OF CIRCUMSTANCES AND/OR CLAIMS TO PROFESSIONAL INDEMNITY INSURERS?

Yes No If Yes, who is the person responsible. If No, please comment.

32. DOES THE APPLICANT HAVE A DOCUMENTED FILE REVIEW PROCEDURE FOR RISKS WHICH IN THE OPINION OF THE APPLICANT ARE HIGH RISK OR NON-STANDARD ACCOUNTS?

Yes No If No, please comment.

33. DOES THE APPLICANT RETAIN ON EACH FILE SUFFICIENT INFORMATION TO RECORD ON EACH FILE WHY A CERTAIN INSURANCE POLICY OR TRANSACTION WAS RECOMMENDED AS BEING SUITABLE FOR CLIENT'S REQUIREMENTS? Yes No If No, please comment.

34. IS A SUMMARY LETTER STATING THE REASONS WHY A CERTAIN POLICY/TRANSACTION WAS RECOMMENDED SENT TO CLIENTS AS A MATTER OF COURSE FOR ALL ACCOUNTS? Yes No If No, please comment.

35. DOES THE APPLICANT HAVE A FORMAL DISASTER RECOVERY PLAN? Yes No If No, please comment.

36. DOES THE APPLICANT RETAIN DAILY OFF-SITE BACKUPS FOR ALL ELECTRONIC DATA? Yes No If No, please comment.

37. IF THE APPLICANT HAS NOTIFIED CLAIMS OR CIRCUMSTANCES TO INSURERS WHAT ACTION HAS THE APPLICANT TAKEN TO REVIEW AND IMPROVE INTERNAL PROCEDURES FOLLOWING THE NOTIFICATIONS TO INSURERS? PLEASE DESCRIBE AND/OR COMMENT.

38. DOES THE APPLICANT USE INSURERS NOT RATED BY BEST'S OR RATED BELOW "B"? Yes No If Yes, please comment.

39. IF THE ANSWER TO QUESTION 38 IS YES, DOES THE APPLICANT WARN CLIENTS ABOUT UN-RATED OR BELOW "B" RATED SECURITY? Yes No If No, please comment.

40. IF THE ANSWER TO QUESTION 38 IS YES, DOES THE APPLICANT VET THE SECURITY? Yes No If No, please comment.

41. DO YOU PLACE ANY RISKS (DIRECTLY OR THROUGH AN INTERMEDIARY OR WHOLESALER) WITH UNLICENSED INSURERS? Yes No

42. WHAT STEPS DO YOU TAKE TO CHECK THE FINANCIAL STRENGTH OF INSURERS YOU USE (DIRECTLY OR THROUGH AN INTERMEDIARY OR WHOLESALER)?

43. DOES THE APPLICANT CURRENTLY CARRY PROFESSIONAL OR ERRORS AND OMISSIONS LIABILITY INSURANCE? Yes No

i) If Yes, please indicate the name of the Insurer:

ii) Please indicate if such coverage is offered on an occurrence basis or claims made basis

Occurrence Claims Made

iii) If current coverage is on a claims made basis, what is the retroactive date? _____

iv) What is your current policy limit? \$_____

v) What is your current deductible? \$_____

vi) If you are presently insured, are renewal terms being offered? Yes No

vii) If No, please state reason:

44. A) HAVE ANY CLAIMS EVER BEEN MADE TO THE KNOWLEDGE OF THE APPLICANT AGAINST THE APPLICANT, ANY BUSINESS PREDECESSORS, OR ANY OF THE PRESENT OR FORMER PARTNERS OR OFFICERS? Yes No

B) IS THE APPLICANT AWARE OF ANY ACT, ERROR, OMISSION OR CIRCUMSTANCES WHICH COULD GIVE RISE TO A CLAIM AGAINST THE APPLICANT OR ANY PREDECESSOR IN BUSINESS, OR ANY PRESENT OR FORMER PARTNER OR OFFICER? Yes No

IF THE ANSWER TO EITHER Q.44 a) OR Q.44 b) IS YES, COMPLETE THE ENCLOSED CLAIMS HISTORY FORM

NOTE: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 44 a) AND/OR 44 b) OR ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

45. HAS ANY PARTNER, EXECUTIVE OFFICER, DIRECTOR OR PROFESSIONAL EMPLOYEE HAD THEIR LICENCE SUSPENDED, BEEN FINED OR REPRIMANDED DURING THE PAST FIVE YEARS?

Yes No If Yes, attach details.

46. TO THE APPLICANT'S KNOWLEDGE, HAS ANY COMPANY DECLINED OR TERMINATED THE INSURANCE FOR THE APPLICANT, ANY PRESENT PARTNER OF OFFICER OR FOR ANY PREDECESSOR IN THE BUSINESS, PAST PARTNERS OR OFFICERS? Yes No

If Yes, provide details:

47. PLEASE NOTE THE PROFESSIONAL ASSOCIATIONS TO WHICH THE APPLICANT BELONGS:

48. WHEN IS YOUR FISCAL YEAR END? _____

49. INSURANCE REQUIRED:

LIMITS:

- \$ 500,000 / 1,000,000
- \$ 1,000,000 / 1,000,000
- \$ 1,000,000 / 2,000,000
- \$ 2,000,000 / 2,000,000
- \$ 5,000,000 / 5,000,000
- Other _____

DEDUCTIBLES:

- \$ 2,500
- \$ 5,000
- \$ 10,000
- \$ 25,000
- Loss Only
- Loss and Litigation Expense

We hereby declare that the above statements and particulars are true and that we have not suppressed or misstated any material facts and we agree that this declaration shall be the basis of any binder or contract of insurance with the Insurance Company, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this application does not bind the Insurance Company to the issue of the insurance nor the Applicant to the purchase of this insurance.

It is further understood and agreed that if, following submission of this application to the Insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 44 a) or 44 b) of this application, the Insurer shall be immediately notified in writing of such information.

Signature of Applicant: _____ Dated: _____

Print Name and Title: _____

Firm Name: _____

BROKER NAME: _____

ADDRESS: _____

PHONE NO: _____

FAX NO: _____

EMAIL ADDRESS: _____



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CLAIMS HISTORY FORM

Applicant Name: _____

Date: _____

Claimant Name: _____

Claimant's Insurer: _____

Policy Number: _____

Type of Cover: _____

Date of Claim: _____

Description of Claim: _____

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
ESTIMATED LIABILITY	\$
INDEMNITY PAID	\$
EXPENSES PAID	\$

Claimant Name: _____

Claimant's Insurer: _____

Policy Number: _____

Type of Cover: _____

Date of Claim: _____

Description of Claim: _____

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
ESTIMATED LIABILITY	\$
INDEMNITY PAID	\$
EXPENSES PAID	\$

Claimant Name: _____

Claimant's Insurer: _____

Policy Number: _____

Type of Cover: _____

Date of Claim: _____

Description of Claim: _____

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
ESTIMATED LIABILITY	\$
INDEMNITY PAID	\$
EXPENSES PAID	\$

Claimant Name: _____

Claimant's Insurer: _____

Policy Number: _____

Type of Cover: _____

Date of Claim: _____

Description of Claim: _____

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
ESTIMATED LIABILITY	\$
INDEMNITY PAID	\$
EXPENSES PAID	\$

Claimant Name: _____

Claimant's Insurer: _____

Policy Number: _____

Type of Cover: _____

Date of Claim: _____

Description of Claim: _____

SUIT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Open <input type="checkbox"/> Closed
AMOUNT CLAIMED	\$
ESTIMATED LIABILITY	\$
INDEMNITY PAID	\$
EXPENSES PAID	\$