TRAVELERS

Travelers 1st Choice+®

Insurance Professionals Liability Coverage
Individual Life, Health And Accident Insurance Agents Or Brokers
Professional Liability Insurance Claims Made Application

☐ **St. Paul Fire and Marine Insurance Company, Saint Paul, Minnesota**
☐ **St. Paul Mercury Insurance Company, Saint Paul, Minnesota**
☐ **St. Paul Guardian Insurance Company, Saint Paul, Minnesota**
☐ **St. Paul Protective Insurance Company, Saint Paul, Minnesota**

(Box should be checked by the underwriter after the appropriate underwriting company is determined.)

Important Note: This is an application for a claims-made policy. To be covered, a claim must be first made against an insured during the policy period or any applicable extended reporting period.

New York Defense Expenses Notice: If this policy contains an insuring agreement that includes defense expenses within the limits of coverage, payment of defense expenses may reduce the professional liability coverage limits up to 50%. If this policy contains an insuring agreement that includes a deductible that applies to defense expenses, up to 50% of the deductible amount may be applied to defense expenses.

All questions must be answered, use ink or typewriter **if not completing electronically**. Submit a current copy of all letterhead used. If the name differs from the name in Question 1a, provide detail on a separate attachment.

Note: This application only applies for an individual agent selling life and health coverage or mutual funds through personal production. If you place business for any employee producers, for other agents or brokers, or for independent contractors or non-employee producers, or if you are involved in any business besides life and health or mutual fund products or services, contact Mercer Consumer at 888-424-2310 and request our standard new business application that will address these other products, services and producers.

Products or operations that do not qualify for this application include but are not limited to: self-insured or self-funded insurance or benefit plans, Multiple Employer Welfare Arrangements (MEWAs), Multiple Employer Trusts (METs), Property and Casualty insurance, and administration activities for benefit plans, pension plans, claims administration or COBRA administration services. If you are unsure if this is the correct application for you, contact Mercer Consumer at the phone number provided above.

1. Applicant Information:

a. Full legal name of Applicant. *Include all agency names, trading names or DBAs under which the applicant operates.

b. Street Address:	c. City:	d. State & Zip:
e. Phone:	f. Fax:	
g. E-mail Address:	h. Website Address:	

i. Ownership type:
☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ LLP ☐ Other:

j. Date established:

k. Do you have any subsidiaries or branch offices? ☐ Yes ☐ No
If yes provide the addresses of each office (use a separate sheet if needed).

l. Are you a member of NAHU? ☐ Yes ☐ No
If yes, please provide member name:

m. Are you a member of any other insurance professional organization? ☐ Yes ☐ No
If yes, describe:

n. During the past five (5) years, has any portion of your business or operations been sold or transferred to another person or business entity? ☐ Yes ☐ No
If yes, provide complete details including the date of the sale or transfer, the amount and type of business or operations, and the person or entity that the business was sold or transferred to.

o. Are you engaged in any other business operations, or do you conduct business under any other name?..... ☐ Yes ☐ No

If yes, provide complete details.

p. Are you affiliated with, associated with, controlled by or represent any other agency, Brokerage or agency cluster type arrangement? ..... ☐ Yes ☐ No

If yes, please attach a detailed description.

2. Business Breakdown:

a. Provide the gross annual commission and fee revenue from life and health products and services provided by your agency (revenue is based on commission income and fees before deduction of expenses). Include commission or fee revenue from mutual funds only if you are requesting this optional coverage.

For the past 12 months..... $

Estimated revenue for next year ..... $

b. Give the approximate percentage breakdown of the total business that is placed by you or your agency as a(n):

Agent (Personal Producing)..... % Consultant (for fee) ..... %

Broker (Personal Producing) ..... % Other (describe on separate sheet) ..... %

c. Break down your total revenues by percentage of professional activities during the past year. Total must equal 100% of total gross revenues in 2a. above.

1. "FULLY INSURED" Life and annuity policies (individual and group) issued by licensed Life Companies ..... %
2. "FULLY INSURED" Health, A&H and Medical policies (individual and group) issued by licensed Life/A&H Companies, Regulated HMOs or Service Plans (Blue Cross/Shield) ..... %
3. Mutual Fund Sales (exclusive of Annuity/Group or Employee Benefit plans)*..... %
4. Any other business activity (Explain using a separate sheet)..... %

**Only provide a percentage for Mutual Funds if you are requesting the optional coverage for Mutual Funds and question 7b is marked "Yes".*

TOTAL 100%

d. Full Names of Life/Accident & Health Companies and % of total business with each:

1st _____ % 4th _____ %

2nd _____ % 5th _____ %

3rd _____ % 6th (total of all other companies) _____ %

If more than 30%, provide name and rating of next 4 carriers

3. Production Sources:

a. Provide the dates you were first licensed and the professional designation(s) you hold.

Licensed Individual*	Life Date	A&H Date	SEC (type/series#)	Professional Designations Held

**Place an Asterisk next to your name if you are licensed in Kentucky.*

b. Indicate the number of unlicensed support staff in your office. .....

c. Indicate the percentage of your total business received:

Direct from your Insureds..... %

From other agents, brokers or non-employee producers who receive payment from you or from your carriers for this business..... %

d. List all states where licenses are held by you:

4. Loss Control Questions:

a. Do you maintain a written office procedure manual? ..... ☐ Yes ☐ No

If yes, does it contain the following?

Procedures for handling all business transactions ..... ☐ Yes ☐ No

File documentation requirements ..... ☐ Yes ☐ No

Agency diary and recall procedures ..... ☐ Yes ☐ No

Job descriptions/responsibilities for each employee ..... ☐ Yes ☐ No

Guidelines for carrier ratings ..... ☐ Yes ☐ No

Company Information ..... ☐ Yes ☐ No

Agency statement regarding training and education ..... ☐ Yes ☐ No

Role of the computer in the agency ..... ☐ Yes ☐ No

b. Have you attended a Sponsored Loss Control Seminar in the past 12 months? (NAHU, NAIFA, PIA, IIA) .... ☐ Yes ☐ No

If yes, include a copy of your seminar attendance certificate.

5. Current Professional Liability Coverage:

a. Indicate your professional liability coverage for the past three years and attach a copy of your last Declarations Page. If no coverage previously existed, please state "none".

Carrier	Policy expiration date	Limits	Deductible	Annual premium	Did coverage include all Products and Carriers?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

b. If you have not carried professional liability coverage for the past three years or have had a gap in coverage, please explain why:

_____

_____

6. Past Professional Liability Claims / Loss History:

a. Have you been the subject of any fines or disciplinary action by any insurance or other regulatory authority? ..... ☐ Yes ☐ No

If yes, attach an explanation.

b. Has any policy or application for professional liability insurance on behalf of the applicant, or to your knowledge on behalf of any preceding insurance related business of yours, ever been declined, canceled or renewal refused within the past 10 years? **(Not applicable if domiciled in Missouri)** ..... ☐ Yes ☐ No

If yes, attach an explanation.

c. Have any professional liability claims been made against the applicant, or to the knowledge of the applicant, on behalf of any preceding business of yours, within the past 5 years? ..... ☐ Yes ☐ No

If yes, please complete a Supplemental Claim Form for each claim.

d. Are there any circumstances which may result in professional liability claims being made against the applicant or any preceding business of yours? ..... ☐ Yes ☐ No

If yes, please complete a Supplemental Claim Form for each claim.

(Note: Claims already made or potential claims that you are aware of prior to the policy inception are not covered).

7. Coverage Desired:

a. Please check the coverage limits and desired deductible:

(*Note: the $100,000/$300,000 limit option and $1,000 deductible is only available to firms with revenue less than $75,000. Availability of some Limit and Deductible options may be subject to underwriting and regulatory restrictions*).

Coverage limits	Deductible
☐ $100,000/$300,000	☐ $1,000 (minimum)
☐ $250,000/$750,000	☐ $2,500
☐ $500,000/$1,500,000	☐ $5,000
☐ $1,000,000/$3,000,000	☐ $7,500
☐ Other $ _____	☐ $10,000
	☐ Other $ _____

b. Optional Coverage:

Is coverage desired for the sale of Mutual Funds? (Coverage for Mutual Fund sales can be added to the policy for an additional premium charge) ..... ☐ Yes ☐ No

If yes, question #2.c.3. Mutual Fund Sales must be completed.

c. **IMPORTANT NOTE: Please include a sample of your stationery letterhead with this application.**

COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Agency Compensation, One Tower Square, Hartford, CT 06183.

FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island
Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado
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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Attention: Insureds in Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania
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. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and Washington
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Attention: Insureds in Oregon
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

YOUR SIGNATURE AND AUTHORIZATION

The undersigned authorized representative of the firm, or individual if this application is for an individual, agrees to all of the following:

- The statements and representations made in this application are true and complete and will be deemed material to the acceptance of the risk assumed by Travelers in the event an insurance policy is issued.
- If the information supplied in this application changes between the date of the application and the effective date of any insurance policy issued by Travelers in response to this application, you will immediately notify us of such changes, and we may withdraw or modify any outstanding quotation or agreement to bind coverage.
- Travelers is authorized to make an investigation and inquiry in connection with this application.
- Travelers is not bound or obligated to issue any insurance policy or to provide the insurance requested in this application.

Signature *(Partner, Member, Officer, Proprietor)*	Title	Date
Print name	Name of Firm	

This application is not a representation that coverage does or does not exist for any particular claim or loss, or type of claim or loss, under any insurance policy issued by Travelers. Whether coverage exists or does not exist for any particular claim or loss under any such policy depends on the facts and circumstances involved in the claim or loss and all applicable wording of the policy actually issued.

INSURANCE AGENT OR BROKER MUST COMPLETE THE FOLLOWING:

Submitting agency name ☐ Direct ☐ Sub-produced

Address (street, city, state, zip code)

Phone _____ Fax _____ Email _____

Licensed producer name _____ License number _____

Please send completed forms to Mercer Consumer, a service of Mercer Health & Benefits Administration LLC, P.O. Box 310179 Des Moines, IA 50331-0179, Telephone: 888-424-2310, Fax: 515-365-0494