



McGOWAN RISK SPECIALISTS
145 Wyckoff Road, Suite 103
Eatontown, NJ 07724
P: 732.450.9730 • F: 440.333.3214
mcgowanrisk.com

MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION

1. **Name of Applicant:** _____
Principal Business Address: _____

Website Address: _____

2. **Limit of Liability Desired:**
 \$250,000 \$500,000 \$1,000,000 \$2,000,000
 \$3,000,000 \$5,000,000 Other _____

3. **Deductible:**
 \$2,500 \$5,000 \$10,000 \$25,000
 Other _____

4. **Please describe in detail the professional services / activities for which coverage is desired:**

5. **Is the applicant engaged in any business or profession other than as described in item 4? YES NO**
If yes, please attach an explanation and estimated revenues.

6. (a) **Projected annual gross revenues for the current year: \$** _____

(b) **Annual gross revenues for three prior years:**

(i) **prior twelve months: Year: _____ \$ _____**

(ii) **first prior year: Year: _____ \$ _____**

(iii) **second prior year: Year: _____ \$ _____**

7. Please provide breakdown of activities / services described in Question 4:

Professional Services	% of Gross Revenues (6a)
_____	_____ %
_____	_____ %
_____	_____ %
_____	_____ %
TOTAL	100 %

8. Applicant is: Corporation Partnership Individual Other: _____

9. Date Organized: _____

10. Is the Applicant Firm controlled, owned, or associated with any other firm, corporation, or company?
 YES NO IF YES, attach an explanation.

Are any activities listed in Question 4 provided to such business enterprise(s)?
 YES NO IF YES, attach an explanation.

11. (a) Number of principals, partners, officers, and professional employees directly engaged in providing services to clients: _____

(b) Number of non-professional employees (clerks, secretaries, etc): _____

12. Please provide the following:

Name(s) of ALL Partners/Principals/Key Employees	PROFESSIONAL QUALIFICATIONS	DATE QUALIFIED	HOW LONG IN PRACTICE?	HOW LONG AS PARTNER/PRINCIPAL?

13. Professional societies and organizations to which the Applicant and its owners, partners, officers and key employee(s) belong:

14. Does the Applicant Firm use a written contract with client?

In all cases Sometimes Never Please attach copy of standard contract (if applicable).

15. Describe Applicant's five largest jobs in the past three years:

Client Name	Professional Services	Gross Revenues
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

16. Does the Applicant utilize the services of independent contractors or subcontractors? YES NO

IF YES, please indicate percentage of gross revenues derived from professional services performed by independent contractors or subcontractors: _____%. Please provide explanation:

17. Has any Insurer canceled, rescinded, non-renewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for this insurance in the last five years? YES NO IF YES, please explain.

18. Is similar insurance currently in force? YES NO IF YES, please provide:

Description of services being covered: _____

Name of Insurer: _____

Expiration Date: _____ Prior Acts/Retro Date: _____

Limit: \$ _____ Deductible: \$ _____ Premium: \$ _____

Length of time coverage has been in force: _____

19. Has the Applicant and/or any of its directors, officers and/or employees its predecessors, subsidiaries, affiliates, employees and/or any other person or entity proposed for this insurance been involved in or have knowledge of any pending or completed governmental regulatory, investigative or administrative proceedings?

YES NO IF YES, please explain.

20. Does any person to be insured have knowledge of information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her?

YES NO IF YES, please complete a Supplemental Claims Information form for each claim.

21. After inquiry have any claims been made against any proposed insured(s) during the past three (3) years?
 YES NO IF YES, please complete a Supplemental Claims Information form for each claim.
 Also, how many claims have been made in the last three (3) years? _____

It is understood and agreed that with respect to questions 19, 20 and 21 above; that, if such knowledge or information exists, any claim or action arising there from is excluded from this proposed coverage.

EPLI OPTION: PLEASE COMPLETE THE FOLLOWING IF YOU WOULD LIKE AN EPLI INDICATION

- A. Number of Employees: Full Time: _____ Part Time: _____ Independent Contractors: _____
- B. % of Employees earning over \$100,000: _____
- C. Any layoffs in past 12 months or anticipated in next 12 months? YES NO IF YES, please furnish details
- D. Any prior claims or circumstances that could lead to a claim? YES NO IF YES, please furnish details
- E. Current Coverage: Name of Insurer: _____ Policy Period: _____
 Limit: \$ _____ Deductible: \$ _____ Premium: \$ _____ Prior Acts/Retro Date: _____
- F. Does the company have any of the following:
 Employee Manual: YES NO Discrimination Policy: YES NO Sexual Harassment Policy: YES NO
 Employment Application: YES NO Utilize any tests for employment: YES NO

The policy applied for is solely as stated in the policy, if issued, which provides coverage on a claims made basis for only those claims that are first made against the insured during the policy period, unless the extended reporting period option is exercised in accordance with the terms of this policy. The policy has specific provisions detailing claim reporting requirements.

The Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide, nor the Applicant to purchase, the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the Company receives notice is on file with the Company and is considered physically attached to and part of the policy, if issued. The Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Company, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I/We warrant to the Company, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to the Company.

Name of Applicant

Title

Signature of Applicant

Date

**COLLECTION AGENCY/MEDICAL BILLING COMPANY
SUPPLEMENTAL APPLICATION**

1. What measures are taken to assure compliance with the Fair Debt Collection Practices Act and/or the Fair Credit Reporting Act?

2. Please provide us with a complete description of standard operating procedures:

3. List the type of clientele service and approximate percentage of total operations each represents:

It is understood and agreed that this supplemental application shall become a part of the application for Professional Liability Errors & Omissions Insurance.

Date

Name of Applicant

Signature of person authorized
to execute on behalf of the Applicant