



Submitted By: \_\_\_\_\_  
Producer: \_\_\_\_\_  
Address: \_\_\_\_\_  
License No.: \_\_\_\_\_

**INDEPENDENT PROPERTY & CASUALTY INSURANCE AGENTS ERRORS AND OMISSIONS LIABILITY INSURANCE APPLICATION**

- A) This application must be completed in full, including all required attachments, dated and signed by an Owner, Partner, Principal, Director, or Officer of the Applicant.
- B) Attach a separate exhibit with the question number if more space is required to answer a question.
- C) Application must be completed in ink or typed.

**I. Applicant's General Information**

1. Name of Applicant Firm (include all legal entities the applicant desires to have identified as a Named Insured):  
\_\_\_\_\_
2. Home Office Mailing Address: \_\_\_\_\_
3. Physical Address (if different from H.O. mailing address): \_\_\_\_\_  
\_\_\_\_\_
4. Contact Person: \_\_\_\_\_
5. Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
6. Website Address: \_\_\_\_\_
7. Date Business Established: \_\_\_\_\_  
**If applicant has been in operation less than three years, please attach a detailed explanation and resumes for all principals which reflect prior insurance experience, education, professional designations, etc.**
8. Current Ownership Structure/ Ownership History  
Applicant is a:  
 Sole Proprietorship  
 Corporation  
 Partnership  
 LLC  
 Other: \_\_\_\_\_

9. a. Does the Applicant have any subsidiaries?  Yes  No  
 b. If yes, does the Applicant desire coverage for the subsidiaries?  Yes  No  
 (Note, the Policy does not cover subsidiaries unless specifically endorsed.)

*If yes, complete and attach Supplement A*

10. Within the last five years have there been:
- a. Changes in the applicant's name?  Yes  No
  - b. Changes in applicant's ownership or principals?  Yes  No
  - c. Mergers / consolidations with / or purchases of other agencies?  Yes  No
  - d. Purchase of other agencies business?  Yes  No  
 If yes, did the purchase include assumption of assets and liabilities?  Yes  No  
 Or Assets only?  Yes  No
  - e. Agency cluster arrangements?  Yes  No

*If yes to any of the above complete Supplement B.*

11. Is there any entity(s) having a 10% or greater interest in the Applicant, any subsidiary and/or affiliate of the Applicant?  Yes  No

If yes, please provide the entity's name, % ownership interest and relationship to Applicant.

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12. Branch Office Information

Number of branch office locations and number of employees at each branch. An individual application is required for each branch office that has separate agency appointments with companies.

Branch Office Location	Number of Employees/Independent Contractors
_____	_____
_____	_____
_____	_____

**II. Personnel and Staffing Information**

(Note, please account for all full time and all part time personnel/staff. A part time person is an individual who works 20 hours or less in a week. Two part time individuals equate to one full-time person.)

Name	Experience			Licensed (check where applicable)			FT	PT
	Years Ins. Experience	Years w/Agency	Professional Designation	Agent	Broker or Solicitor	Surplus Lines		
A. Licensed Owners, Principals, Partners, Directors & Officers								
<b>Total</b>								

Name	Experience			Licensed (check where applicable)			FT	PT
	Years Ins. Experience	Years w/Agency	Professional Designation	Agent	Broker or Solicitor	Surplus Lines		
B. Licensed Solicitors, Producers & Consultants who are Employees of the Applicant								
<b>Total</b>								

Name	Experience			Licensed (check where applicable)			FT	PT
	Years Ins. Experience	Years w/Agency	Professional Designation	Agent	Broker or Solicitor	Surplus Lines		
C. All other Employees, Owners, Partners, Officers, Directors, & Producers								
<b>Total</b>								

Name	Experience			Licensed (check where applicable)			FT	PT
	Years Ins. Experience	Years w/Agency	Professional Designation	Agent	Broker or Solicitor	Surplus Lines		
D. Solicitors, Producers, Officers, Brokers who are not Employees of the Applicant (1099s)								
<b>Total</b>								

Total number of Applicant's personnel/staff members: (A + B + C + D) \_\_\_\_\_  
 Annual employee turnover rate in each of the last three years \_\_\_\_\_% \_\_\_\_\_% \_\_\_\_\_%

**III. Applicant Revenue/Commission Information**

		Previous 36 Months	Previous 24 Months	Last 12 Months	Estimated Next 12 Months
a).	Total P&C gross written annual premium:				
b).	Total gross annual P&C commissions:				
c).	Total Life and A&H gross written premium:				
d).	Total gross annual Life and A&H commissions:				
e).	Total annual income derived from other insurance related activities:				

**IV. Carrier Information**

1. List the current top five insurance companies for whom you produce premium. If the total equals less than 75% of your agency's total premium written, please list additional insurance carriers and volume on a separate sheet.

Insurance Company Name	Annual Premium Volume	Binding Authority	Major Lines Placed	Years Represented	Best Rating
	\$	<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			

2. What percent of business is placed with: Admitted Carriers: \_\_\_\_\_% Non-Admitted: \_\_\_\_\_%
3. List ALL insurance companies, currently rated NR or B+ or less by A.M. Best for which you placed business over the last three years.

Insurance Company Name	Annual Premium Volume	Binding Authority		Major Lines Placed	Years Represented
	\$	<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		

4. Does the Applicant maintain a contract with each carrier?  Yes  No  
 If yes, does the contract have hold harmless wording or bilateral indemnification?  Yes  No
5. In the past three years has any carrier or other risk bearing entity used become insolvent, bankrupt, put into rehabilitation or receivership?  Yes  No
6. Has any agency contract been cancelled by a carrier in the last three years?  Yes  No

*If yes to 5. or 6, attach exhibit with a detailed explanation.*

7. Does the Applicant provide any services to Professional Employer Organizations (PEO's) or any similar organizations?  Yes  No

*If yes, complete and attach Supplement C*

**V. Mix of Business Summary**

1. Written business by Annual Gross Written Premium Volume for most recent fiscal year: (MUST total last 12 months figure amount indicated in Section III. above.)

COMMERCIAL LINES		
CMP/Package	\$	%
CGL/BOP	\$	%
Umbrella/Excess	\$	%
Auto-Standard/Plan	\$	%
Auto-Non-Standard/Plan	\$	%
Long Haul Trucking	\$	%
Workers Compensation	\$	%
Livestock Mortality	\$	%
Crop Coverage's	\$	%
Medical Malpractice	\$	%
Professional Liability-(Specify)	\$	%

Wet Marine	\$	%
Inland Marine	\$	%
Bonds/Surety	\$	%
Bonds-All Other	\$	%
Aviation	\$	%
Products Liability	\$	%
Other (Specify)	\$	%
<b>TOTAL COMMERCIAL LINES</b>	\$	<b>100 %</b>

PERSONAL LINES			LIFE AND A&H INSURANCE		
Auto-Standard	\$	%	Life, Individual	\$	%
Auto- Non-Standard	\$	%	Life, Group	\$	%
Homeowners	\$	%	A&H, Individual	\$	%
Non-Standard Fire	\$	%	A&H, Group	\$	%
Pleasure Boats	\$	%	Annuities	\$	%
Mobile Homes/RVs	\$	%	HMO/PPO/DSP	\$	%
Motorcycles	\$	%	Dental Plans	\$	%
Wind/Flood/EQ	\$	%	Health Plans	\$	%
Umbrella	\$	%	Health Savings Accounts	\$	%
Other (Specify)	\$	%	401(K) Plans	\$	%
<b>TOTAL PERSONAL LINES</b>	\$	<b>100 %</b>	Other (Specify)	\$	%
			<b>TOTAL LIFE and A&amp;H</b>	\$	<b>100 %</b>

2. Property and Casualty Business Placed As:

2b. \*\* If the applicant operates as a MGA/ MGU or Program Administrator complete supplemental application (D).\*\*

Retail agent / broker (business placed directly with carriers)	%
Broker/Wholesaler	%
Managing General Agent/Underwriter	%
Reinsurance Intermediary	%
Surplus Lines Broker	%
	<b>Total 100%</b>

3. Percentage of policies written on a direct bill basis: \_\_\_\_\_ %

4. Percentage of gross written premium placed through a service center: \_\_\_\_\_ %

5. Percentage of gross written premium placed through a state administered fund: \_\_\_\_\_ %

6. Percentage of business written through MGA's, other brokers or intermediaries: \_\_\_\_\_%

7. Does the Applicant place any business as an MGA or MGU?  Yes  No

*If yes, please complete and attach Supplement D*

8. Does the Applicant place mutual funds through a securities broker/dealer that is affiliated with an insurance company?

*If Mutual Funds coverage is desired complete and attach Supplement E.*

9. Does the Applicant perform any of the following activities? If yes, attach resume(s), promotional materials and sample contract(s). Please include revenue in Section III. above.

		<b>Revenue/Income</b>
a). Reinsurance Intermediary	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
b). Third Party Administrator	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
c). Claims Adjustment Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
d). Investment/Securities Advisor	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
e). Banking or Loan Origination	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
f). Legal Adviser/Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
g). Actuarial Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
h). Tax Adviser	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
i). Risk Management/Loss Control	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
j). Consulting	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
k). Title Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
l). Mortgage/Mortgage Service Facility	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
m). Real Estate	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
n). Data Processing Consulting	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
o). Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

10. In the past five years, has the Applicant:

a). Placed coverage's for risks involved in Petroleum exploration and extraction, mineral exploration and mining, hazardous waste operations or operations with significant pollution exposures?  Yes  No

b). Specialized in any programs or classes of business?  Yes  No

c). Placed coverage or been involved in Self Insured/Captives, Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), or Multiple Employer Trusts (MET), or Multiple Employer Welfare Arrangements (MEWA)?  Yes  No

If either of the above are answered Yes, please attach an explanation, including the name of the program(s), carrier(s), extent of coverage(s) provided, administrative duties performed by the Applicant, and any applicable financial information. For 10C please also provide a copy of the promotional literature.

**VI. Information regarding Applicant's Electronic Commerce Activity**

1. Does Applicant use its website for the following:

- a. advertising?  Yes  No
- b. marketing?  Yes  No
- c. online quotes and/or on-line binders?  Yes  No

If yes to c., describe specifically which parts of the insurance transaction the Applicant uses its website to conduct? Are the policies, procedures and controls that exist for non on-line transactions in place for on-line transactions?  Yes  No

**VII. Staff Training and Education Information**

1. What percentage of the Applicant's staff attended an approved Insurance Agent's E&O Continuing Education Program or Loss Prevention Seminar in the last 12 months? \_\_\_\_\_

2. What Programs do the staff attend, ie. Name of Sponsor, Type of Program, etc.?  
\_\_\_\_\_

3. Briefly describe the Applicant's policy on training and loss prevention education.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Are in-house training session regularly conducted by the Applicant?  Yes  No  
If yes, how often are they conducted and who conducts them? \_\_\_\_\_  
\_\_\_\_\_

**VIII. Office Controls and Procedures:**



1. Does the agency utilize a computerized production, billing & accounting system and is there a back- up for the system?  Yes  No
2. Does the agency have an exposure analysis checklist?  
If yes, how often are exposures reviewed with insureds? \_\_\_\_\_  Yes  No
3. Is the agency on-line with any carrier?  
Name of carrier: \_\_\_\_\_ Volume with carrier: \_\_\_\_\_  Yes  No
4. Does the agency upload data to carriers?  
If yes, how often, and does it involve all carriers? \_\_\_\_\_  Yes  No
5. Does the agency have means to allow carriers to download data to Agency systems?  
If yes, how often, and does it involve all carriers? \_\_\_\_\_  Yes  No
6. Is incoming mail date stamped?  Yes  No
7. Are copies of binders mailed to the insured and/or the company within specified guidelines?  Yes  No
8. Is there a procedure for documenting telephone conversations?  Yes  No
9. Is a policy expiration list maintained?  Yes  No
10. Are all applications, policies and endorsements checked for accuracy?  Yes  No
11. Are files marked to ensure certificate holders, regulatory agencies, etc., are notified of cancellation or material changes?  Yes  No
12. Is there a back-up procedure for when agency personnel are away from the office?  Yes  No
13. Does the agency have a diary/suspense system?  
If yes, is it automated?  Yes  No  
 Yes  No
14. Does applicant have an Office Manual?  Yes  No
15. Does applicant have a specific orientation program/office manual review for all new employees?  Yes  No
16. Does the agency have a disaster recovery plan?  Yes  No
17. Is there are full time IT person dedicated to all automated systems?  
If no, please explain \_\_\_\_\_  Yes  No

### **IX. Claims History:**

1. Has any prospective insured, or any employees, ever been subject to an investigation

by a state regulatory agency, administrative agency and/or an insurance department investigation or inquiry or disciplinary investigation or proceeding in any way?  Yes  No

If Yes, please provide an explanation: \_\_\_\_\_

2. Has any prospective insured, or any of its employees, ever had their license revoked, suspended, or been fined or disciplined by any state regulatory department?  Yes  No

If Yes, please provide an explanation: \_\_\_\_\_

3. Has any policy or application for Errors and Omission insurance on behalf of the Applicant, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors ever been declined, cancelled or renewal refused within the last five (5) years?  Yes  No

If Yes, please provide an explanation: \_\_\_\_\_

4. During the past five (5) years, has any claim or notice of claim been made or suit brought against the Applicant, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors?  Yes  No

5. Is the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors aware of any fact, circumstance, situation, allegation, contention or incident which may result in a claim being made against the Applicant, its predecessor (s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors?  Yes  No

*If Yes to any of the questions numbered 1 through 5, complete and attach Supplement F.*

**It is understood and agreed that, without limiting any rights of the underwriter, if such knowledge or information exists, any claim arising therefrom is excluded from this proposed insurance.**

**X. Previous Coverage:**

List Errors and Omissions carriers/information for the last 3 years. (If none, state "none").

Name of Carrier	Policy Period	Limits of Liability	Deductible	Premium	Retro Date
a). _____	_____	\$_____/ \$_____	\$_____	\$_____	_____
b). _____	_____	\$_____/ \$_____	\$_____	\$_____	_____
c). _____	_____	\$_____/ \$_____	\$_____	\$_____	_____

**XI. Coverage Requested:**

1. Limits of Liability: Please indicate the limit of liability desired:

**PER CLAIM/ AGGREGATE FOR THE POLICY PERIOD**

<input type="checkbox"/> \$ 500,000/ \$ 500,000	<input type="checkbox"/> \$ 5,000,000/ \$ 5,000,000
<input type="checkbox"/> \$ 1,000,000/ \$ 1,000,000	<input type="checkbox"/> Other
<input type="checkbox"/> \$ 2,000,000/ \$ 2,000,000	

2. Retention: Please indicate the retention desired:

Indicate your choice of a retention from the options listed below. The Insurer might require a higher retention and proof of financial ability to pay a retention. In selecting the retention, please remember that the retention applies to the payment of Loss and Defense Expenses.

RETENTION AMOUNT/EACH LOSS	
<input type="checkbox"/> \$ 5,000	<input type="checkbox"/> \$ 25,000
<input type="checkbox"/> \$ 10,000	<input type="checkbox"/> \$ 100,000
<input type="checkbox"/> \$ 15,000	<input type="checkbox"/> Other

3. Retroactive Date Desired \_\_\_\_\_

**THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY NSM Insurance Group.**

**WRITING OF SUCH CHANGES. NSM Insurance Group RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.**

**THE UNDERSIGNED AUTHORIZED OWNER, PARTNER, DIRECTOR, OR OFFICER REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS/ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH HEREIN AND ATTACHED HERETO ARE TRUE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE UNDERWRITER ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE UNDERWRITER.**

**NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.**

**NOTICE TO COLORADO APPLICANTS: 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.**

**NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.**

**NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

**NOTICE TO KENTUCKY 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 COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.**

**NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.**

**NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.**

**NOTICE TO NEW JERSEY APPLICANTS: 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.**

**NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.**

**NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.**

**NOTICE TO PENNSYLVANIA APPLICANTS: 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.**

**APPLICANT UNDERSTANDS AND AGREES THAT THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO ISSUANCE OF AN INSURANCE POLICY.**

**Signature of Applicant:** \_\_\_\_\_  
**(Must be signed by an Owner, Partner, Director, or Officer of the Named Insured. It is agreed the signer has authority to act on behalf of all insureds.)**

**Printed Name of Applicant:** \_\_\_\_\_

**Title** \_\_\_\_\_

**Date:** \_\_\_\_\_



Please Fax or Email  
**Completed Application To:**

(201) 847-9174  
[apps@plrisk.com](mailto:apps@plrisk.com)