

This form can only be used to provide a premium indication. It does not replace the required carrier application. There is no guarantee a firm quote will be offered or coverage provided.

Contact name _____ Agency name _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Fax _____ Email _____
 Website _____ Is your website encrypted? Yes No
 Date agency established (ex. 12/30/2007) _____ Number of locations _____
 Years of insurance experience _____ Years of experience as an independent agent _____
 List any agency associations/alliances/clusters/aggregators to which you belong _____

Staff size

(include ALL owners, principals, officers, producers, support staff, W-2s, 1099s, licensed and non-licensed employees, full-time and part-time)

Agency Employees

Full-time employees:
 licensed _____ unlicensed _____
 Part-time employees (20 hrs/wk or less):
 licensed _____ unlicensed _____

Property/Casualty premium volume \$ _____
 Property/Casualty commissions \$ _____
 Life/Health commissions \$ _____
 Consulting/fees \$ _____

Independent Contractors

Full-time (earning more than \$25,000 comm.):
 licensed _____ unlicensed _____
 Part-time (earning less than \$25,000 comm.):
 licensed _____ unlicensed _____

Percent of business placed

Directly with admitted carriers _____%
 Directly with surplus lines carriers/through surplus lines brokers _____%
 Through other agencies _____%
 Accepted from other agencies _____%

As an MGA _____%
 As a TPA _____%

Carrier information

List top 3 primary carriers and percentage of business placed with each:

1. _____ %
 2. _____ %
 3. _____ %

Percent rated B+ or better? _____%

Please continue to next page.

Product Lines

Personal Lines _____%	+	Life and Health _____%	+	Commercial Lines _____%	=	100%
_____% Non-Standard Personal Lines		_____% Individual Life		_____% Bonds		
_____% Standard Personal Lines		_____% Group Life		_____% Workers' Comp		
		_____% Individual Health		_____% Long Haul Trucking		
		_____% Group Health		_____% Medical Malpractice		
				_____% Crop		
				_____% Specialty Lines - please describe		

Claims Information

1. Within the last five years, has anyone in your agency reported an incident or claim to your E&O carrier? Yes No
2. Within the last five years, have any of your E&O carriers paid a claim on your behalf? Yes No
This would include any money paid for damages and/or expenses.

NOTE: If you marked "Yes" to either claim questions, please provide details on the attached claims supplement form.

Agency Procedures/Operations

Employee handbook	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date stamp mail	<input type="checkbox"/> Yes <input type="checkbox"/> No
Office procedure manual	<input type="checkbox"/> Yes <input type="checkbox"/> No	Staff training program	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tickler/follow-up system	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exposure analysis checklist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paperless?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Agency management system	<input type="checkbox"/> None <input type="checkbox"/> AMS <input type="checkbox"/> Applied <input type="checkbox"/> SIS <input type="checkbox"/> Doris <input type="checkbox"/> Other _____		
Most recent E&O loss prevention seminar attended (month/year) _____		# of staff attended _____	
Does 60% of your staff have an insurance designation? (CIC, CISR, CPCU, LUTCF, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Current E&O Coverage Information/Coverage Desired

Carrier _____ Expiration date _____ Retroactive date _____

Premium _____ Limits: Each loss _____ Aggregate _____

Deductible _____ Deductible type: Loss only Loss plus expense Years of continuous E&O _____

Desired limit _____ Desired deductible _____ Desired effective date _____

Additional Coverages Desired

- Employment practices liability
- Cyber liability
- Mutual funds (series 6 or 63 licensed) # of licensed staff _____
- Commercial umbrella (will extend over E&O)
- Stocks, bonds, & mutual funds (series 7 licensed) # of licensed staff _____
- Real estate Limit _____ Deductible _____ # of licensed staff _____ % of agency income _____

Signature _____ Date _____