Return application to:
CB Malaga Insurance Services LLC
tel: 877-245-5887
fax: 805-426-8540
email: info@cbspecialty.com

TRAVELERS

Miscellaneous Professional Liability Coverage Application

Travelers Casualty and Surety Company of America
Travelers Casualty and Surety Company *(only applicable in Guam, Puerto Rico, and the Virgin Islands)*

NOTICE

ALL LIABILITY COVERAGE PARTS FOR WHICH APPLICATION IS MADE APPLY, SUBJECT TO THEIR TERMS, ONLY TO CLAIMS FIRST MADE OR DEEMED MADE AGAINST INSUREDS DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD, IF APPLICABLE. THE LIMIT OF LIABILITY AVAILABLE TO PAY LOSSES WILL BE REDUCED BY THE AMOUNTS INCURRED AS DEFENSE EXPENSES, AND DEFENSE EXPENSES WILL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY HAS NO DUTY TO DEFEND ANY CLAIM UNLESS DUTY–TO-DEFEND COVERAGE IS SPECIFICALLY PROVIDED.

The term **Applicant** means all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

1. **Applicant** Information:

   Name of **Applicant**: _____

   Street Address: _____

   City, State, ZIP Code: _____

   Website Address: _____

   Year **Applicant's** business was established: _____

   Description of **Applicant's** operations: _____

2. **Applicant's** Standard Industrial Classification (SIC) code, if known (4-digit number): _____

3. Is the **Applicant** a subsidiary of a foreign parent? Yes ☐ No ☐

4. Does the **Applicant** currently file, or does it anticipate filing in the next 6 months, any documents with the Securities and Exchange Commission or similar foreign authority regarding any equity or debt securities? Yes ☐ No ☐

II. ORGANIZATION INFORMATION

1. Describe all entities the **Applicant** owns *(Check here if not applicable* ☐*)*:

Name	% Owned	Year Started	Description of Operations	Entity Type*
	%			
	%			

***Entity Type: FP=For-Profit (other than Partnership); NP=Non-Profit; GP=General Partnership; LP=Limited Partnership; LLC=Limited Liability Company**

To enter more information, please attach a separate page to the Application.

2. In the next 12 months (or during the past 24 months) is the **Applicant** contemplating (or has the **Applicant** completed or been in the process of completing) the following:

   a. Any actual or proposed merger, acquisition, or divestiture? Yes ☐ No ☐

   b. Any creation of a new business, subsidiary, or division? Yes ☐ No ☐

   c. Any registration for a public offering or a private placement of securities? Yes ☐ No ☐

d. Any reorganization or arrangement with creditors under federal or state law? Yes ☐ No ☐

e. Any branch, location, facility, office, or subsidiary closings, consolidations, or layoffs? Yes ☐ No ☐

If any of the questions above were answered Yes, please attach an explanation, including the timing, the essential terms of the event, arrangement, and the surrounding circumstances.

III. PROFESSIONAL INFORMATION

1. Describe, in detail, all professional services offered by the **Applicant**:

Professional Services	% of Total Revenue	% of Revenue Sub-Contracted
	%	%
	%	%
	%	%

To enter more information, please attach a separate page to the Application.

2. Indicate **Applicant's** revenue for the following years:

Prior Fiscal Year	Current Fiscal Year	Estimated for Next Fiscal Year
$	$	$

3. Describe the **Applicant's** 5 largest projects or jobs during the past 3 years:

Client Name	Services Rendered	Annual Revenue Derived From the Project or Job
		$
		$
		$
		$
		$

4. If sub-contractors are used, does the **Applicant** require evidence of professional liability insurance? Yes ☐ No ☐

5. Is a written contract or agreement required for each client? Yes ☐ No ☐
*If Yes, please attach a sample. If No, please attach an explanation detailing how responsibilities are defined between the **Applicant** and their client.*

6. Has the **Applicant** sued to collect past or overdue fees from clients within the past 2 years? Yes ☐ No ☐
If Yes, please attach an explanation.

7. Does the **Applicant** use:

a. A procedure manual? Yes ☐ No ☐

b. A formal training program? Yes ☐ No ☐

8. Indicate the number of **Applicant's** employees:

Principals/Partners, Officers, Professionals	Clerical/Non-Professional

9. Indicate the following information for all Principals/Partners, Officers, and professional employees:

Name	Title	Professional Designation	# of Years Experience in Practice	# of Years With Applicant

To enter more information, please attach a separate page to the Application.

10. List all professional associations to which the **Applicant** belongs: _____

IV. CURRENT INSURANCE INFORMATION/REQUESTED INSURANCE TERMS

Requested Limit	Requested Retention	Requested Effective Date	Coverage Currently Purchased	Current Insurer
$	$		Yes ☐ No ☐	

Expiring Limit	Expiring Retention	Expiring Premium	Date Coverage First Purchased	Current Retroactive Date
$	$	$		

1. What is the **Applicant's** preference for defense coverage? Duty to Defend ☐ Reimbursement ☐

V. LOSS INFORMATION

1. Is the **Applicant** or any person proposed for this insurance aware of any fact, circumstance, situation, event or act that reasonably could give rise to a claim against them under the Liability Coverage for which the **Applicant** is applying? Yes ☐ No ☐
   If Yes, please attach an explanation.

*With respect to the information required to be disclosed in response to the question above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the **Applicant** had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy*.

2. Has any person or entity proposed for this insurance been a party to any professional liability claims, any disciplinary actions, or been cited by any regulatory agency or professional association during the past 5 years? Yes ☐ No ☐
   If Yes, please complete the table below:

Date of Such Claim	Nature of Claim	Amount Paid for Defense	Amount Sought or Paid for Damages	Covered by Insurance?	Corrective Procedures Implemented	Current Status
		$	$	Yes ☐ No ☐		
		$	$	Yes ☐ No ☐		

To enter more information, please attach a separate page to the Application.

VI. REQUIRED ATTACHMENTS

As part of this Application, please submit the following documents (*these documents, and the representations and facts they contain, are made a part of this Application, whether such documents are physically delivered to the Company by the **Applicant** or are obtained by the Company from any public source, including the Internet*):

- Copies of standard contracts and engagement/proposal letter used with clients if policy limit requested is greater than $1,000,000
- Biographical sketches/resumes of all Principals, Partners, and key employees if in business less than 3 years
- Brochures, advertisements, or other descriptive literature about the **Applicant** firm, its operations, and activities, if not available on website
- Most recent annual financial statement, if:
  - **Applicant** is a public company; or
  - **Applicant** is not a public company, but revenues exceed $7,000,000 or policy limit requested is greater than $3,000,000

VII. 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, Enterprise Development, One Tower Square, Hartford, CT 06183.

VIII. 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.

IX. SIGNATURE SECTION

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE (PARTNER, PRINCIPAL OR OTHER OFFICER ACCEPTABLE TO TRAVELERS) OF THE APPLICANT DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, AFTER REASONABLE INQUIRY, THE STATEMENTS SET FORTH IN THE ATTACHED TRAVELERS NEW BUSINESS OR RENEWAL APPLICATION FOR INSURANCE ARE TRUE AND COMPLETE AND MAY BE RELIED UPON BY TRAVELERS. IF THE INFORMATION IN ANY APPLICATION CHANGES PRIOR TO THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY MODIFY OR WITHDRAW ANY OUTSTANDING QUOTATION. THE COMPANY IS AUTHORIZED TO MAKE INQUIRY IN CONNECTION WITH THIS APPLICATION.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE COMPANY TO OFFER, NOR THE APPLICANT TO PURCHASE, THE INSURANCE. IT IS AGREED THAT THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, SHALL BE THE BASIS OF THE INSURANCE AND SHALL BE, IN ALL STATES OTHER THAN NC AND UT, CONSIDERED PHYSICALLY ATTACHED TO AND PART OF THE POLICY, IF ISSUED. THE COMPANY WILL HAVE RELIED UPON THIS APPLICATION, INCLUDING ANY MATERIAL SUBMITTED THEREWITH, IN ISSUING THE POLICY.

ELECTRONICALLY REPRODUCED SIGNATURES WILL BE TREATED AS ORIGINAL.

Signature* of **Applicant's** Authorized Representative (Partner, Principal or Officer)

Name (Printed)

Title

Date

***IF YOU ARE ELECTRONICALLY SUBMITTING THIS APPLICATION TO TRAVELERS, APPLY YOUR ELECTRONIC SIGNATURE TO THIS FORM BY CHECKING THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX BELOW. BY DOING SO, YOU HEREBY CONSENT AND AGREE THAT YOUR USE OF A KEY PAD, MOUSE, OR OTHER DEVICE TO CHECK THE ELECTRONIC SIGNATURE AND ACCEPTANCE BOX CONSTITUTES YOUR SIGNATURE, ACCEPTANCE, AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING AND HAS THE SAME FORCE AND EFFECT AS A SIGNATURE AFFIXED BY HAND.**

AUTHORIZED REPRESENTATIVE'S ELECTRONIC SIGNATURE AND ACCEPTANCE ☐

X. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA AND NEW HAMPSHIRE):

Producer Signature

Producer Name (Printed)

CB Malaga Insurance Services LLC

Agency Name

Agency Code

License Number

TRAVELERS

Miscellaneous Professional Liability
Medical Billing Additional Information Request

Travelers Casualty and Surety Company of America

Travelers Casualty and Surety Company *(only applicable in Guam, Puerto Rico, and the Virgin Islands)*

THE INFORMATION BEING REQUESTED IS FOR A CLAIMS-MADE POLICY. IT IS IMPORTANT THAT YOU READ ALL OF THE PROVISIONS OF YOUR POLICY CAREFULLY.

DEFENSE EXPENSES ARE INCLUDED WITHIN THE LIMITS OF COVERAGE AND RETENTION, AND SUCH LIMITS MAY BE COMPLETELY EXHAUSTED BY THE PAYMENT OF DEFENSE EXPENSES. THE COMPANY WILL NOT BE LIABLE FOR DEFENSE EXPENSES OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT AFTER EXHAUSTION OF THE LIMITS OF COVERAGE.

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise.

GENERAL INFORMATION

Proposed Named Insured:		Today's Date:
Proposed Effective Date *(mm/dd/yyyy):*	Proposed Expiration Date *(mm/dd/yyyy):*	

MEDICAL BILLING INFORMATION

1. What percentage of revenue is generated from the following?
   - Billing _____ %
   - Coding _____ %
   - Accounts Receivable _____ %
   - Claim Processing _____ %
   - Auditing _____ %
   - Collections _____ %
   - Other _____ %
2. If collection services are provided to what extent do you pursue delinquent payments? _____
   _____
3. Is your compensation related to the amount billed or collected? ..... ☐ Yes ☐ No
   If yes, explain: _____
   _____
4. What percent of services are provided to the following?
   - Hospitals _____ %
   - Clinics _____ %
   - Nursing Homes _____ %
   - Private Practices _____ %
   - Government Agencies _____ %
   - Other _____ %
5. What percentages of your billings are for Medicare or Medicaid?
   Medicare _____% Medicaid _____%
6. Are you currently and always been in compliance with all applicable privacy laws and regulations? ..... ☐ Yes ☐ No
   If no, explain: _____
7. Are you currently, and have you always been, in compliance with all applicable privacy laws and regulations? ..... ☐ Yes ☐ No
8. Do you conduct internal audits? ..... ☐ Yes ☐ No

9. Do you have written policies and procedures for standards of conduct? ☐ Yes ☐ No

10. Do you have a compliance officer and committee? ☐ Yes ☐ No

11. Do your contracts disclaim all responsibility for verification of medical charges submitted to you by your clients? ☐ Yes ☐ No

FRAUD STATEMENTS – Attention Applicants in the Following Jurisdictions:

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, 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.

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.

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.

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.)

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.

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.

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.

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

SIGNATURES

I acknowledge that this document is to be read in conjunction with the core application and that all notices contained therein are deemed fully incorporated herein. I also affirm that any declarations made in the core application regarding the information contained therein also apply to the information contained herein, including any material submitted herewith.

Authorized Representative Signature:* **X**	Authorized Representative Name - Printed:	Date:
Producer Signature: * **X**	State Producer License No. (required in FL):	Date:

Agency:	Agency Contact:	Agency Phone Number:

* If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative
☐ Electronic Signature and Acceptance – Producer

