

**ERRORS AND OMISSIONS INSURANCE APPLICATION
LIFE/A&H INSURANCE AGENTS/AGENCIES**

NOTICE: This is an application for claims made and reported insurance. Such insurance if accepted by the Company, subject to policy provisions, applies only to those claims which are the result of wrongful acts occurring subsequent to the Retroactive Date and which are first made against you and reported to us during the policy term or any applicable Extended Reporting Period. The policy provides that the limit of liability shall be reduced by the amounts paid for legal defense.

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

**** Please attach a copy of the declarations page from your current policy (if applicable) ****

1a Applicant's Name _____ DBA (if applicable) _____
Mailing Address _____
City _____ State _____ Zip _____
Phone (____) _____ Fax (____) _____ Email Address _____
Contact Person _____ Title _____

1b Does the applicant own 100% of the listed DBA?..... Yes No N/A

1c Does the applicant own any business entities not listed on the application?..... Yes No

1d Please list any additional insureds _____ Additional named insureds _____

2 Applicant is: Sole Proprietorship Partnership Corporation

3 Date first licensed: Life/Health* ____/____/____ Series 6 (if applicable) ____/____/____ Series 7 (if applicable) ____/____/____
**If less than three years, provide resumes for each agency principle.*

4 Please check the professional designations you currently hold:
 CLU RHU LUTCF ChFC CIC REBC CPCU RPLU Other _____

5 Has the applicant been involved with any mergers, purchases or, acquisitions in the past five years? Yes No
If yes, please describe on a separate sheet.

6 Has the applicant ever had any professional license terminated or suspended? Yes No

7 Have any professional liability claims been made against the applicant or any of its past or present owners, officers, partners, employees, or solicitors, or to the knowledge of the applicant on behalf of its predecessors in business, within the last five years?
If yes, a Supplemental Claim form must be completed and submitted with this application. The Supplemental Claim Information Form is available on the web at www.rockwoodinsurance.com in the Life Agents E&E section. Yes No

8 Are there any known circumstances or incidents which may result in a professional liability claim? Yes No
If yes, give details on a separate sheet.

9 Declarations of "LICENSED" persons, (including yourself), whether owners, partners, directors, officers, or employees (selling or not).

a	NAME OF LICENSED PERSON	DESIGNATIONS CODE*	REVENUE	
			LAST 12 MONTHS	NEXT 12 MONTHS
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____

b Total Number of sub-agents, brokers, and independent contractors _____ \$ _____ \$ _____

*Designation Codes: O = Owner P = Partner OF = Officer/Director
E = Employee **If necessary, use a separate sheet.**

Total Revenue: \$ _____ \$ _____

c Unlicensed Staff: Total Number _____ Full Time _____ Part Time _____

1099 employees are excluded by the policy form, unless added by endorsement. Please note that the policy covers the applicant for any liability resulting from the actions of independent contractors so long as the revenues from independent contractor(s) are indicated above, subject to policy terms and conditions.

10 Do you verify that all non-employed sub-agents/independent contractors are required to carry Errors and Omissions coverage? Yes No

11 Please indicate percentages of the applicants revenue derived from each line of business written below: **The total of all lines should equal 100%.**

____ % Life-Individual ____ % A&H-Individual ____ % Stocks ____ % Variable Annuities
____ % Life-Group ____ % A&H-Group ____ % Bonds ____ % Equity Indexed Annuities
____ % Fixed Annuities ____ % Mutual Funds ____ % RIA/Financial Planning ____ % All Other (Describe on a separate sheet)
* ____ % Pension/Employee Benefit Planning * ____ % Insurance Consulting Please provide a brief description on a separate sheet.

12a Does the applicant require coverage for Financial Products (Mutual Funds and Variable Annuities)? Yes No
If "Yes", what is the annual commission income derived from Variable Annuities? \$

NOTE: Restrictions apply. A supplemental Financial Products Questionnaire must be completed so eligibility can be determined.

12b Does the applicant require coverage for Investment Services (Stocks, Bonds, RIA/Financial Planning)? Yes No
If Yes, an additional premium will apply.

12c Do you charge fees for investment services or advice? Yes No

12d Does the applicant require coverage for incidental Property & Casualty placements? Yes No

If "Yes", what is the annual commission income derived from P&C related activity? \$

NOTE: Restrictions apply. A supplemental P&C Activities Application must be completed so eligibility can be determined.

NOTE: The activities listed in questions 12a and 12b are subject to a sublimit: actions selling variable annuities, mutual funds, stocks bonds; actions as a financial planner/registered investment advisor.

13 If "Yes" to 12a and/or 12b please provide: Name of Broker Dealer
Name of Registered Representative(s)

14 Does the Applicant offer premium financing on any accounts? Yes No If "Yes", what percentage of total premium is financed? %

15 Does the applicant place coverage or have involvement with Self Insured/Captives or Risk Retention Groups (RRG), Risk Purchasing Groups (RPG), Mutiple Employer Trusts (MET), Multiple Employer Welfare Arrangements (MEWA), Stop Loss Products or any self funded or partially funded product? Yes No If yes, please provide a brief description of activities in this area (on a separate sheet).

16 List the top five Insurance Companies with which you place business:
Table with 3 columns: Name of Insurance Company, Products Sold, % of Revenues

17 Do you currently have Errors and Omissions Insurance in Force? Yes No
If "Yes", what is: Name of Insurer Expiration Date

Retroactive Date Current Limits \$ Deductible \$ Premium \$

Do you wish to purchase prior acts coverage? Yes No NOTE: Prior Acts coverage may only be available if the applicant has had continuous coverage in force with no gaps. If the applicant has not carried coverage or is not able to provide proof of coverage, the retroactive date of the policy will be inception. If "Yes", proof of prior coverage will be required.

18 Limits of liability desired \$ Deductible amount desired \$

THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY. SUCH POLICY MAY BE CANCELLED BY THE COMPANY FROM INCEPTION UPON DISCOVERY THAT THE POLICY WAS OBTAINED THROUGH FRAUDULENT STATEMENT, OMISSION, OR CONCEALMENT OF THE FACTS MATERIAL TO THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED BY THE COMPANY.

THE APPLICANT REPRESENTS THAT THE STATEMENTS AND RESPONSES TO THE QUESTIONS ON THIS APPLICATION ARE ACCURATE AND COMPLETE. APPLICANT ALSO WARRANTS THAT SUCH STATEMENTS AND RESPONSES ARE TRUE, CONTAIN NO MISREPRESENTATIONS AND THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION OR ATTACHMENTS THERETO CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY, THE APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES.

Signature (Must be signed by an owner or officer of the applicant) Date

Please Print Name Title

Referred by: Agent Name E-mail Tel ()