



**Technology Professional Liability**

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.  
**THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY.**

**Section I: Background Information**

1. Name of Insured: \_\_\_\_\_
2. Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Website: \_\_\_\_\_ Date Established: \_\_\_\_\_
3. Is the Applicant controlled, owned, affiliated or associated with any other firm, corporation or company?  
 Yes  No If **Yes**, please provide details: \_\_\_\_\_
4. Does the Applicant have any subsidiaries?  Yes  No If **Yes**, please list on a separate sheet and advise if coverage is to apply to them.

**Section II: Organization Operations Details:**

5. Please describe in detail the professional services for which coverage is desired: \_\_\_\_\_

6. (a) List total gross receipts from activities in question #5

	<b>Gross Receipts</b>
Last Year:	\$ _____
Current Year (based on 12 months):	\$ _____
Forecast for New Year:	\$ _____

- (b) Please indicate the percent of receipts listed in 6a from Operations outside of the U.S. and its territories: \_\_\_\_\_
- (c) Did the Applicant have a positive net income in the past 12 months?  Yes  No
- (d) What is the Applicant's overall net equity?  Positive  Negative  
 If **Negative**, please advise net equity and steps being taken to correct the negative net equity. (on a separate sheet)

7. (a) Please indicate the percentage of Applicant's gross receipts from the last fiscal period involving:

Web Site Design	_____ %
Training and Education	_____ %
Record Management/Retrieval	_____ %
Hardware Maintenance Services	_____ %
Package Software Installation	_____ %
Computer Security	_____ %
Custom Software Development	_____ %
Equipment Evaluation and Selection	_____ %
Needs Evaluation	_____ %
Package Software Development / Sales	_____ %
Hardware Manufacturing / Sales	_____ %
Other Technology Related Services (please describe)	_____ %
Non-Technology Services (please describe)	_____ %
<b>Total (must equal 100%)</b>	_____ %

(b) Does the Applicant provide any services which enable or affect any of the following:	<b>Yes</b>	<b>No</b>	<b>% Receipts</b>
CAD/CAM design or control, robotics or process control of industrial equipment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mechanical, electrical, chemical, civil or architectural design or engineering?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fund transfers or financial transactions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aircraft, air-ground equipment, military defense and/or weaponry of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical, dental or healthcare diagnosis, monitoring or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharmaceutical formulation, production or prescriptions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
911 or other emergency response and/or dispatch?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Energy, power plant, utility or pollution monitoring, supply or distribution?	<input type="checkbox"/>	<input type="checkbox"/>	_____

8. (a) Is the Applicant an Internet Service Provider and/or does it provide any Internet access, online publishing, and/or services as a web host, web search engine, e-mail service, chat room, online database or bulletin board?  
 Yes     No    If **Yes**, please provide details on a separate sheet.
- (b) Does the Applicant provide such services via their own server?     Yes     No

9. Describe the 5 largest jobs or projects during the past 3 years

Name of Client	Services Provided	Gross Billings
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. (a) Please provide the following:

Names of Partners, Principals, Key Employees and Independent/Qualifications/ Sub Contractors	Professional in Practice Designations	# of Years
_____	_____	_____

(b) Is the Applicant a licensed Professional (i.e. Lawyer, Accountant...)?     Yes     No    If **Yes**, advise type of licensed Professional: \_\_\_\_\_

(c) Number of principals, partners, officers and professional employees directly engaged in providing services to clients: \_\_\_\_\_

(d) Number of non-professional employees (clerks, secretaries, etc.): \_\_\_\_\_

(e) Number of independent/subcontractors: \_\_\_\_\_

11. Does the applicant utilize independent contractors?     Yes     No

If Yes, please answer the following question(s) regarding the use of independent contractors.

(1) How will the Applicant utilize each independent/subcontractor? \_\_\_\_\_

(2) The total percent of Applicant's work done by independent/subcontractor. \_\_\_\_\_

(3) Does the Applicant require Certificates of Professional Liability Insurance from all independent contractors?     Yes     No

12. What do you see as your potential exposure to a professional liability claim? \_\_\_\_\_  
 \_\_\_\_\_

13. Does the Applicant use a written contract or letter of engagement with clients?

In all Cases     Sometimes     No

**Section III: Claims Information**

*Do not complete this section if this is an application for a renewal policy at the same limit of liability with one of the USLI Companies.*

14. During the past 5 years, has any claim been made or suit brought against the Insured, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors?     Yes     No  
**(If Yes, please provide details on a separate supplemental claim application.)**

15. Is any owner, partner, officer, director, employee or independent contractor aware of any circumstance, allegation, contention, or incident which may result in a claim being made against the Insured, its predecessor(s) in business, or any of its present or former partners, owners, officers, directors, employees or independent contractors?     Yes     No  
**(If Yes, please provide details on a separate supplemental claim application.)**

**Section IV: Professional Liability Insurance Coverage**

16. Has any Policy of or Application for professional liability insurance on your behalf or on the behalf of any of your principals, officers, employees, independent contractors, or on behalf of any predecessor(s) in business ever been declined, cancelled or non-renewal refused?     Yes     No

If **Yes**, advise details: \_\_\_\_\_

17. Is similar professional liability insurance currently in force?     Yes     No

Name of Carrier	Limit	Retro date (if any)	Deductible	Premium	Policy Period
_____	_____	_____	_____	_____	_____

Length of time coverage has continuously been in force: \_\_\_\_\_

**Section V: General Liability Insurance**

18. Does the Applicant currently have General Liability Insurance?  Yes  No  
Name of Carrier \_\_\_\_\_ Limit \_\_\_\_\_ Premium \_\_\_\_\_ Expiration Date \_\_\_\_\_

19. Describe any General Liability Losses in the past 5 years: \_\_\_\_\_

20. (a) Number of Employed Consultants/Persons rendering Professional Services as described in Question 5: \_\_\_\_\_

(b) Does the applicant use Independent Contractors?  Yes  No If Yes, please answer 25 (b) and (c).

(c) Is General Liability coverage to include Independent Contractors?  Yes  No

(d) Number of Independent Contractors used: \_\_\_\_\_

21. Is the Applicant involved in electrical work, wiring and/or cable installation of the items for which they are providing consultation services? (including work done by Independent Contractors on behalf of the Applicant.)  Yes  No

22. Additional Insureds to be included (list names, address and relationship to Applicant): \_\_\_\_\_

**Section VI: Personal Property Insurance**

23. (a) Personal Property Limit (at 80% Coinsurance/Replacement Cost): \_\_\_\_\_

(b) EDP Equipment Limit \$ \_\_\_\_\_

(c) Burglar Alarm  Yes  No Central Station  Yes  No

Sprinklers  Yes  No Central Station  Yes  No

Fire Alarm  Yes  No Central Station  Yes  No

24. Property Protection Class (1-10): \_\_\_\_\_

25. If located in first tier coastal county, distance from water (ocean, bay or inlet): \_\_\_\_\_

26. Property Claims Paid or Pending during 5 years: \_\_\_\_\_

**SECTION VII: Required Information**

A. USLI Application.

**ARIZONA, PENNSYLVANIA AND OREGON FRAUD STATEMENT:** 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 MAY BE SUBJECT TO A CIVIL PENALTY (AND A CRIMINAL PENALTY IF IN PENNSYLVANIA).

**UTAH, CONNECTICUT, OHIO FRAUD STATEMENT:** 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.

**VIRGINIA FRAUD STATEMENT:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, SUBMITS AN APPLICATION FOR INSURANCE OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**FRAUD STATEMENT (ALL OTHER STATES):** 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 THOUSANDS DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

THE STATES OF FLORIDA AND NEW YORK REQUIRE THAT WE HAVE THE NAME AND ADDRESS OF YOUR (INSURED'S) AUTHORIZED AGENT OR BROKER.

NAME OF AUTHORIZED AGENT OR BROKER \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
LICENSE NO. \_\_\_\_\_  
MAIL COMPLETED \_\_\_\_\_  
APPLICATION THROUGH \_\_\_\_\_  
LOCAL AGENT OR \_\_\_\_\_  
BROKER TO: \_\_\_\_\_

Signature of Applicant or Insured: \_\_\_\_\_

Must be signed by a Principal, Partner or Officer of the Firm

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

## SUPPLEMENTAL CLAIMS APPLICATION

When any one of the Claims Questions is answered "Yes", please complete this form for **each Claim**.

1. Name of Claimant? \_\_\_\_\_

2. When did Claim occur? \_\_\_\_\_

3. Details and background of Claim \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Has the EEOC or State Human Rights Agency ruled on this case? Yes \_\_\_\_\_ No \_\_\_\_\_ .

If Yes, was ruling A. Probable Cause \_\_\_\_\_ B. No Probable Cause \_\_\_\_\_

(PLEASE ATTACH A COPY OF THE RULING).

5. What is the Status of the Claim? \_\_\_\_\_

6. Amount of Defense Costs Paid? \_\_\_\_\_

7. Settlement Amount? \_\_\_\_\_

8. Was the Claim filed with Insurer? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, was the Claim

covered by Insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

9. If Claim is still open, what amount of Reserve has been set up by the Insurer? \_\_\_\_\_

10. What remedial measures have been taken to prevent a recurrence of a similar

Claim? \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(By President or Chairman of Board of Insured)

The information on this supplemental Application is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as if physically attached hereto.

## DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, effective November 26, 2002, that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, *as defined in Section 102(1) of the Act*. The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property; or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

**YOU SHOULD KNOW THAT ANY COVERAGE FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. UNDER THIS FORMULA, THE UNITED STATES PAYS 90% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.**

**COVERAGE FOR "INSURED LOSSES" AS DEFINED IN THE TERRORISM RISK INSURANCE ACT OF 2002 AS AMENDED IS SUBJECT TO THE COVERAGE TERMS, CONDITIONS, AMOUNTS AND LIMITS IN THIS POLICY APPLICABLE TO LOSSES ARISING FROM EVENTS OTHER THAN ACTS OF TERRORISM.**

**YOU SHOULD KNOW THAT UNDER FEDERAL LAW, YOU ARE NOT REQUIRED TO PURCHASE COVERAGE FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM**

### **REJECTION OR SELECTION OF TERRORISM INSURANCE COVERAGE**

Please "X" one of the boxes below and return this notice to the Company.

	I decline to purchase Terrorism Coverage. I understand that I will have no coverage for losses arising from acts of Terrorism.
	I elect to purchase coverage for certified acts of Terrorism for a premium of \$ _____.

**Note: if you do not respond to our offer and do not return this notice to the Company, you will have no Terrorism Coverage under this policy.**

\_\_\_\_\_  
Applicant's Name

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date