



- ACE American Insurance Company
- Illinois Union Insurance Company
- Westchester Fire Insurance Company
- Westchester Surplus Lines Insurance Company

ACE Advantage[®]

Miscellaneous Professional Liability Renewal Application

NOTICE

The Policy for which you are applying is written on a claims-made and reported basis. Only claims first made against the Insured and reported to the Company during the Policy Period are covered subject to the Policy Provisions

The Limits of Liability stated in the Policy are reduced, and may be exhausted, by Claims Expenses. Claims Expenses are also applied against your Retention, if any. If you have any questions about coverage, please discuss them with your insurance agent.

INSTRUCTIONS

Please type or print all answers clearly. Answer all questions completely, leaving no blanks. If there is insufficient space to complete an answer, please continue on a separate sheet indicating the question number. If any questions, or any part thereof, do not apply, print N/A in the space. Insert checks in Yes or No answer boxes, if any. This Application must be completed, signed, and dated by an authorized officer of your firm. Underwriters will rely on all statements made in this application.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

ADDITIONAL INFORMATION REQUIRED

Please submit the following information with the application:

- a. Standard contract, including sales/service contract, vendor contract and/or contract with subcontractors;
- b. Marketing, advertising or promotional material;
- c. Business resumes of Applicant's key professionals if Applicant's annual revenues are less than \$15,000,000 or Applicant's business has been in existence for less than two years;
- d. Most recent annual report if Applicant is a privately-held company.

1. General Information:

Applicant Name: _____

Business Address: _____

Business Type: Corporation Partnership Limited Liability Company
 Other

Nature of Business: _____

Year Established: _____

Number of Principals, Partners, Directors, Officers, and Professional Employees: _____

Total Number of Employees: _____

URL Addresses for All Public-Facing Websites: _____

2. Professional Services:

Please provide a comprehensive description of the professional services performed by the Applicant for which coverage is desired, and describe any new services provided over the past year. **Attach a separate sheet if necessary.** _____

3. Subsidiaries:

List all Subsidiaries for which coverage is desired. For purposes of completing this question, Subsidiary means any entity that is not formed as a joint venture of which the Applicant owns or has the right to vote more than 50% of the outstanding voting securities representing the present right to vote for election of directors, or the managers or members of the board of managers or equivalent executives of a limited liability company or partnership, on or before the inception date of the Policy. Please provide percentage ownership by Applicant:

Subsidiary Name	Percentage of Ownership	Acquisition or Formation Date	Services Performed by the Subsidiary
	%		
	%		
	%		
	%		

4. Please provide the applicable percentage of revenues derived from the services indicated in Questions 2 and 3 above:

Services Provided	Percentage of Revenue
	%
	%
	%
	%
	%

5. Acquisition, Name Change:

a. Has the applicant changed its name? Yes No

If Yes, please provide an explanation and previous name used by the Applicant.

b. Has the applicant acquired or been acquired by another company? Yes No

If Yes, please provide the names of the company and explanation.

c. Is the acquired or acquiring firm in the same business as the applicant? Yes No

If No, please provide an explanation.

6. Has the Applicant experienced any change in the nature of its business in the past 12 months, including but not limited to substantial increase in or reduction of staffing (net change of +/- 10% or greater), any change in business strategy, structure or plan, or any other material change in business? Yes No

If Yes, please provide an explanation.

7. Clients:

Complete the following for the Applicant's 5 largest clients for the past three years:

Client	Professional Services Provided	Revenues
1.		\$
2.		\$
3.		\$
4.		\$
5.		\$

8. Financial Information:

- a. Indicate fiscal year end date: ____/____ (month/day)
- b. Indicate the following for all **Professional Services** indicated in Questions 2 and 3.

	Year	Revenues	Percentage Non-US Revenues
Prior Fiscal Year			
Current Fiscal Year			
Projected Next Fiscal Year			

9. Subcontractors:

- a. Does the Applicant use subcontractors? Yes No
- b. What percentage of the professional services indicated in Questions 2 and 3 is subcontracted out? _____%

10. Contracts:

- a. What percentage of the Applicant's services is provided under written agreement? _____%
- b. In those instances when written contracts are not used, please explain why. _____

11. Disaster Recovery Planning (to be completed by any Applicant with annual revenues greater than \$100,000,000):

- a. Does the Applicant have a Disaster Recovery Plan currently in place for catastrophic events? Yes No
 - i. Does plan contain Threat Analysis Process? Yes No
 - ii. Does plan contain Risk Assessment Procedure? Yes No
 - iii. Does plan contain Disaster Mitigation Steps? Yes No
 - iv. Does plan contain Response and Recovery Plans? Yes No
- b. Does the Disaster Recovery Plan include planning for terrorist events? Yes No
- c. Has the Applicant tested the Disaster Recovery Plan within the past 6 months? Yes No
- d. Does the Applicant have a Disaster Recovery Team, with specific assignments for team members? Yes No
- e. Is Disaster Recovery Team Leader a part of Senior Management within Applicant's organization?: Yes No

12. Do any principals, directors, officers, partners, professional employees or independent contractors of the Applicant have knowledge or information of any act or omission that might reasonably be expected to give rise to a claim that has not been reported during the past year? Yes No Please provide details including the date of loss, date of service, demand amount, circumstance and alleged wrongful acts, plaintiff and service provided. Please note that this does not constitute the reporting of a claim or incident to the Company and any claims or incidents should be reported to the Company in accordance with the terms of the expiring policy.

FRAUD WARNING STATEMENTS

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete 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 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.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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.

NOTICE TO 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 include imprisonment, fines and denial of insurance benefits.

NOTICE TO WEST VIRGINIA 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 fines and confinement in prison.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS. PLEASE READ CAREFULLY

BY SIGNING THIS APPLICATION, THE APPLICANT REPRESENTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION, SUPPRESSED OR CONCEALED. THE UNDERSIGNED AGREES THAT IF AFTER THE DATE OF THIS APPLICATION AND PRIOR TO THE EFFECTIVE DATE OF ANY POLICY BASED ON THIS APPLICATION, ANY OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE UNDERSIGNED SHALL NOTIFY THE COMPANY OF SUCH OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

Applicant's Signature:

(Must be signed by an Officer of the Applicant)

Print Name and Title

____/____/____
Date (Mo./Day/Yr.)

FOR FLORIDA APPLICANTS ONLY:

Agent Name

Agent License Identification Number

FOR WYOMING APPLICANTS ONLY:

PLEASE ACKNOWLEDGE AND SIGN THE FOLLOWING DISCLOSURE TO YOUR APPLICATION FOR INSURANCE:

I UNDERSTAND AND ACKNOWLEDGE THAT THE POLICY FOR WHICH I AM APPLYING CONTAINS A DEFENSE WITHIN LIMITS PROVISION WHICH MEANS THAT CLAIMS EXPENSES WILL REDUCE MY LIMITS OF LIABILITY AND MAY EXHAUST THEM COMPLETELY. SHOULD THAT OCCUR, I SHALL BE LIABLE FOR ANY FURTHER CLAIMS EXPENSES AND DAMAGES.

Applicant's Signature:

(Must be signed by an Officer of the Applicant)

Print Name and Title

_____/_____/_____
Date (Mo./Day/Yr.)