New Business Application For Lawyers Professional Liability Insurance

Value Plan

Complete this application to qualify for the Lawyers Professional Liability Value Plan.

If you can respond "True" to all of the eligibility statements below, you qualify for the Lawyers Professional Liability Value Plan.

About Your Firm (The precise name of the applicant firm to be insured, as reflected on the firm's letterhead)

FIRM NAME

ADDRESS

CITY | COUNTY | STATE | ZIP

TELEPHONE | FAX

EMAIL | WEB SITE

Eligibility

1. All members of the firm are licensed attorneys. ❑ True ❑ False
2. The firm's professional staff is 2 or less. ❑ True ❑ False
3. The firm's gross annual revenues were less than $35,000 per attorney. ❑ True ❑ False
4. The firm does not practice in any of the following areas of practice: Securities, Intellectual Property, or Personal Injury Plaintiff ❑ True ❑ False
5. The firm does not practice in more than one state. ❑ True ❑ False
6. The firm does not desire coverage for predecessor firms. ❑ True ❑ False

During the past 5 years:

7. The firm has been claims-free. ❑ True ❑ False
8. No member of the firm has been suspended or been the subject of any disciplinary action. ❑ True ❑ False
9. No member of the firm has been or is aware of any act or omission that may reasonably be expected to be the basis of a claim against them, the firm, any predecessor firm, or against any current or former attorney of the firm while they were affiliated with the firm. ❑ True ❑ False

If your firm has responded "True" to all statements in the "Eligibility" section above, your firm qualifies as eligible for the CNA Lawyers Professional Liability Value Plan. Please complete the information on the reverse side and return it as soon as possible. Once your application is received, we'll send you a personalized coverage and rate quotation.

Firm Practice Information

10. Date firm established: ___________________
11. Desired effective date of coverage: ___________________
12. Gross annual revenue for last calendar year: $___________________
13. Estimated revenue for current calendar year: $___________________
14. Attorney information:

Attorney Name	Attorney Desig.	States Licensed to Practice Law	# of Years in Practice	# of Years with this Firm	# of Years Continuous Malpractice Coverage	Prior Acts Date	CNA Risk Mgmt Seminar Date	Bar Member? Yes / No

Attorney Designations:
A = Associate
CC = Co-counsel
D = Director
E = Employee
IC = Independent Contractor
MEM = Member of Firm
MGR = Manager
O = Owner
OC = Of Counsel
OF = Officer
SP = Solo Practitioner
SPC = Special Counsel
STC = Staff Counsel
SHH = Shareholder
STH = Stockholder

Partner Designations:
EP = Equity Partner
NP = Non-equity Partner
P = Partner
RP = Retired Partner
LLP = Limited Liability Partner

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Firm Practice Information (cont'd)

15. Does the firm currently carry lawyers professional liability insurance? ❑ Yes ❑ No
    If "yes" provide the following:
    a. Name of insurance carrier: ____
    b. Policy expiration date: ____ / _____ / _____
    c. Prior acts date / Retroactive date: ____ / _____ / _____ or provide a copy of the firm's current Declarations page.
16. Coverage Selection:
    Limits of Liability (per claim/aggregate): ❑ $100,000/$300,000 ❑ $250,000/$250,000 ❑ $500,000/$500,000 ❑ $1,000,000/$1,000,000
    Deductible (per claim): ❑ $0 ❑ $1,000 ❑ $5,000

Signature and Representation

Applicant hereby represents, after inquiry, that the information contained herein and in any supplemental applications or forms required hereby, is true, accurate and complete and that no material facts have been suppressed or misstated. Applicant acknowledges a continuing obligation to report to the Company as soon as practicable any material changes in all such information, after signing the application and prior to issuance of the policy, and acknowledges that the Company shall have the right to withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance based upon such changes.

Further, Applicant understands and acknowledges that:

1. If a policy is issued, the Company will have relied upon, as representations: this application, and any supplemental applications, and any other statements furnished to the Company in conjunction with this application, all of which are hereby incorporated by reference into this application and made a part hereof.
2. This application will be the basis of the contract and will be incorporated by reference into and made part of such policy; and
3. Applicant's failure to return to its current insurance company any claim made against it during the current policy term, or act, omission or circumstance which Applicant is aware of which may give rise to a claim before the expiration of the current policy may create a lack of coverage.

Applicant hereby authorizes the release of claim information to the Company from any current or prior insurer of the Applicant.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Applicant:

____ / /

SIGNATURE OF OFFICER OR PARTNER OF THE FIRM PRINT NAME OF OFFICER OR PARTNER DATE

HEALTH AGENCIES OF THE WEST, INC.

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