Request for CNA Premium Indication

Firm: ______________________ Contact Person: ______________________
Street Address: ______________________
City: ______________ State ______ Zip: __________
Phone: ______________ Fax: ______________ E-Mail Address: ______________

1 Please provide the following information on each attorney:

Name	Years in private practice	Years of continuous coverage

Include additional attorneys on a separate page.

2 Please tell us what percentage of **Billable Hours** you spend in the following areas of practice:

% of Time Area of Practice

________% Banking / Financial Institutions
________% Business Transaction /Commercial Law
________% Civil / Commercial Litigation - Defense
________% Civil / Commercial Litigation - Plaintiff (not personal injury)
________% Civil Rights / Discrimination
________% Collection and Bankruptcy
________% Consumer Claims
________% Corporate and Business Organization
________% Criminal
________% Environmental Law
________% Family Law
________% Government Contracts / Claims
________% Immigration / Naturalization
________% Intellectual Property - (Copyright, Trademark, Patent)
________% International Law
________% Labor Management Representation
________% Labor Union / Employee Representation
________% Local Government
________% Natural Resources / Oil and Gas
________% Construction (Building Contracts)
________% Personal Injury / Property Damage - Defense
________% Personal Injury / Property Damage - Plaintiff
________% Real Estate / Title - Commercial
________% Real Estate / Title - Residential
________% Securities (SEC)
________% Taxation
________% Wills, Estates, Probate & Planning
________% Workers' Compensation -Defense
________% Workers' Compensation - Plaintiff
________% Other______________________
(please describe below)

100 % Total

3 Please tell us about your current coverage:

Number of years of continuous coverage: __________
Year firm was established: __________
Retroactive Date (if any) ____/____/____

____
Current Professional Liability Carrier / Program

______________ $______________
Current Policy Expiration Date — Annual Premium

______________ ______________
Current Limits — Deductible

4 Desired limits and deductible if different than current policy?

______________ ______________
Desired Limits — Desired Deductible

5 Have you reported any Professional Liability claims or incidents in the last five years? ❒ Yes* ❒ No

*Please provide a detailed explanation, including payments and expenses.

6 In the past two years, has the firm sued a client for fees?

❒ Yes ❒ No If yes, how many times? ________

7 Have any attorneys attended a CNA sponsored loss control seminar in the last three years? ❒ Yes ❒ No If Yes, Name(s) of Attorney(s):

____
Date(s) of Seminar(s): ______________________

8 Have any of the firm's attorneys been the subject of any disciplinary proceedings within the last five years?

❒ Yes ❒ No If yes, please attach an explanation.

9 Does the firm handle any Class Action or Mass Tort cases?

❒ Yes ❒ No

Health Agencies of the West, Inc.
For more information, contact us at:

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Orange, CA 92868
Phone: (800) 556-0800 ■ Fax: (714) 769-3010
E-mail: Info@HealthAgencies.com

Health Agencies of the West is the exclusive CNA administrator for all Arizona and New Mexico firms up to 35 attorneys.

Fax the form back to us at: (714) 769-3010 or email it to info@HealthAgencies.com

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