

Travelers Casualty and Surety Company of America
 Hartford, Connecticut

Important Note: This is an application for a claims-made policy. To be covered, a claim must be first made against an insured during the policy period or any applicable extended reporting period.

Defense Expenses Notice (For New York Only): If this policy contains an insuring agreement that includes defense expenses within the limits of coverage, payment of defense expenses may reduce the professional liability coverage limits up to 50%. If this policy contains an insuring agreement that includes a deductible that applies to defense expenses, up to 50% of the deductible amount may be applied to defense expenses.

Throughout this application "you" and "your" means the entity or individual applying for this insurance.



PLEASE READ:

- You are not eligible for this application **IF** you or your law firm:
- ▶ consists of more than 10 Attorneys
 - ▶ requests a limit of liability greater than \$2,000,000
 - ▶ generates billings or revenues from any of the following areas of practice:
 - SEC/Bond
 - Class Action/Mass Tort
 - Patent Work

IF INELIGIBLE: Standard Firm Application forms are available from your agent or online at Travelers.com.

APPLICANT INFORMATION

1. New Business: Date Firm was established _____ Renewal:
 Effective date requested _____ Travelers policy number _____
2. Firm legal name: _____
3. Firm "trade" or "doing business as" name: _____
4. Street Address: _____ City: _____ State: ___ Zip Code: _____ County: _____
 Primary contact: _____ Title: _____ Phone: _____ Fax: _____
 Email: _____ Firm website address: _____ Legal Status: _____
 (Sole Practitioner, GP, LLP, LLC, PC/PA, Other)

Please list additional office locations at the end of the application or in a separate attachment. If New Business or if your letterhead has changed in the past 12 months, please attach a sample copy.

GENERAL INFORMATION

5. Please list all attorneys associated with your firm:

Name	Position (See Key Below)	Year Admitted to Bar	State(s)	Mo./Yr Joined Firm	Annual Hrs. Worked if < 1000	CLE Hrs. in Past 12 Mo.	Pro Bono Hrs. in Past 12 Mo.

- O = Owner/Officer/LLC Shareholder/Member
- A = Associate Practicing for your Firm
- P = Partner of the Partnership
- RP = Retired Partners of your Firm
- S = Sole Practitioner
- OC = Of Counsel Attorney
- CA = Attorneys on Contract or Per Diem
- EA = Employed Practicing Attorneys of the Firm not otherwise Designated

6. Please indicate total number of non-attorney employed staff: _____

7. Is your firm a part-time legal practice (if < 1000 hours per year practicing law)? Yes No
8. Does anyone employed by your firm provide professional or business services other than the private practice of law? Yes No
If yes, please provide details at the end of the application or in a separate attachment.
9. If you are a sole practitioner, please give the name and address of the back up attorney assigned to handle cases in the event of an extended absence from your practice: _____
10. Please estimate the percentage of your firm's gross billings or revenues in each area. The total must equal 100%.

Area of Practice (AOP)	Percentage of Practice	Area of Practice (AOP)	Percentage of Practice
Administrative	%	Environmental Litigation	%
Admiralty-Defense	%	Foreign	%
Admiralty-Plaintiff	%	Health Care	%
Anti-trust/Trade Regulation	%	Immigration/Naturalization	%
Appellate	%	Insurance Coverage	%
Arbitration/Mediation	%	Investment Counseling/Money Management	%
Aviation	%	Labor Law-Management	%
Banking/Financial Institutions (F.I. Practice Supplement)	%	Labor Law-Union	%
Bankruptcy	%	Labor Litigation-Defense	%
BI/PI Defendant General Liability	%	Labor Litigation-Plaintiff	%
BI/PI Defendant Medical Malpractice	%	Litigation-General-Defense	%
BI/PI Defendant Other	%	Litigation-General-Plaintiff *	%
BI/PI Defendant Products Liability	%	Mergers & Acquisitions	%
BI/PI Plaintiffs General Liability *	%	Municipal/Governmental-Other	%
BI/PI Plaintiffs Medical Malpractice *	%	Municipal/Governmental-Zoning	%
BI/PI Plaintiffs Other *	%	Oil/Gas/Minerals (Oil/Gas/Minerals Supplement)	%
BI/PI Plaintiff Product Liability *	%	Probate/Wills/Trusts/Estates *	%
Civil Rights/Discrimination	%	Public Utilities	%
Collection/Repossession	%	Real Estate-Commercial *	%
Commercial Law	%	Real Estate-Escrow Agent *	%
Communication/FCC	%	Real Estate-Residential *	%
Construction/Building Contracts	%	Real Estate-Syndication/Development *	%
Consumer Claims	%	Real Estate-Title Work (Title Agency Supplement)	%
Copyright/Trademark ONLY	%	School Law	%
Corporate-General	%	Social Security Law	%
Corporate Formation	%	Taxation Corporate-Opinions	%
Criminal	%	Taxation Corporate-Prep	%
Domestic Relations	%	Taxation-Individual	%
Eminent Domain	%	Water Rights Law	%
Employee Benefits/ERISA	%	Workers Compensation-Defense	%
Entertainment/Sports	%	Workers Compensation-Plaintiff	%
Environmental	%	Other (<i>Please describe at the end of the application or in a separate attachment</i>)	%

For Areas of Practice with an asterisk (*), please complete the Estates and Trusts, Plaintiff and Real Estate Supplement.

PLEASE NOTE: For New Business, please complete the listed underwriting supplement if applicable. **For Renewals**, supplements are not required unless the Area of Practice either: (1) is new this year, or (2) has increased by at least 15% within the prior year.

11. Please estimate the percentage of firm revenues or billings that are generated from the following:
- a. High net worth individuals (more than \$10,000,000 in assets) _____ %
 - b. Large Public Companies (more than \$100,000,000 in revenues) _____ %
 - c. Large Private Companies (more than \$100,000,000 in revenues) _____ %

12. Please provide the following information on your top 3 clients generating the largest revenues for your firm:

Name	Industry	Client's Annual Revenues or Est. Net Worth	Legal Services Provided	Percentage of Firm Billings or Revenues	Number of Years as a Client

13. Please indicate gross revenue amounts for the applicable fiscal year: *(Newly established firms estimate current fiscal year only.)*

Estimate for the Current Fiscal Year	\$
Actual for Immediate Past Fiscal Year	\$
Actual for Second Previous Fiscal Year	\$

If yes for Questions 14 -16, please provide details at the end of the application or in a separate attachment.

14. Do you provide any unique or exclusive products or services that are not available from other law firms? Yes No

15. Has any present or past financial institution client become insolvent, merged, undergone regulatory investigation or administration, or ceased operations within the past 6 years? Yes No

16. Within the past 5 years, have any of your attorneys:

a. referred a client to any business organization in which any firm member or spouse ever served as a director, officer, partner, trustee, fiduciary or owned an equity or financial interest? Yes No

b. served as a fiduciary, director, officer, partner or trustee for any client or owned an equity or financial interest in any client?..... Yes No

If yes, please complete the Outside Interest or Estates and Trusts Supplement. For Renewals, only complete such supplements for previously unreported matters.

RISK MANAGEMENT

If yes for Questions 17 & 18, please provide details at the end of the application or in a separate attachment.

17. Within the past 5 years, have you instituted any legal proceedings to collect legal fees? Yes No

18. Are any services provided through prepaid legal service plans or under an alternative billing structure other than an hourly rate and plaintiff contingent fees? Yes No

19. What percentage of your outstanding billings are over 90 days past due? _____%

20. Do you share office space with any firm or attorney(s) who are not members of your firm? Yes No

21. Please indicate if your firm has the following Risk Management system, policy, or procedure: (a) in use, and (b) in place for all (client) matters:

	In Use:	All Matters:		In Use:	All Matters:
a. Computerized Dual Docket Control	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Fee Collection Practices	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. New Client Acceptance Standards	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Engagement Letters	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Computerized Conflict of Interest	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Non-Engagement Letters	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Client Communication Policies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Termination Letters	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional detail on your Risk Management procedures can be provided at the end of the application or in a separate attachment.

PRIOR INSURANCE AND CLAIM HISTORY

Complete Questions 22 & 23 on the following page for New Business ONLY.

22. Please complete the following chart for all predecessor firms for whom coverage is desired: (Additional detail can be provided at the end of this application or in a separate attachment.)

Name of Predecessor Firm	Date Established	Date Dissolved	% of Principals, Owners, Officers or Partners Who Joined the Successor	At Least 50% of Assets Assumed by Successor <input type="checkbox"/> Yes <input type="checkbox"/> No

23. a. What is the inception date of your first Lawyers Professional Liability policy which has been maintained without interruption?
- b. Please complete the following chart for all Lawyers Professional Liability insurance coverage carried by your firm during the past 4 years: (If currently uninsured, please check here .)

	Carrier	Policy Period	Limits	Deductible	Premium	Number of Attorneys	Retroactive Date(s)
Current Year							
Prior Year 1							
Prior Year 2							
Prior Year 3							

If yes for Questions 24 & 25, please provide details at the end of the application or in a separate attachment.

24. Has any person or entity seeking coverage under this proposed policy ever been declined professional liability insurance or had such insurance non-renewed or cancelled, other than for non-payment of premium? (Missouri Applicants: Do not complete this question.) Yes No
25. Has any attorney in your firm ever had a disciplinary complaint filed with any court, administrative agency or regulatory body, or been disbarred, suspended, reprimanded, sanctioned or held in contempt? Yes No
26. During the past 7 years, has any professional liability claim or suit been made or brought against your firm, a predecessor firm, or any current or former firm member? Yes No
If yes, please complete a Claim, Suit, or Incident Supplement for each claim or suit.
27. Do you or any member or employee of your firm have knowledge of any incident, act, error, or omission that is or could be the basis of a claim under this proposed professional liability policy? Yes No
If yes, please complete a Claim, Suit, or Incident Supplement for each incident, act, error, or omission.

COMPENSATION NOTICE

Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website: http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers Agency Compensation, One Tower Square, Hartford, CT 06183.

FRAUD WARNINGS

Attention: Insureds in Alabama, Arkansas, D.C., Maryland, New Mexico, and Rhode Island

Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Attention: Insureds in Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Attention: Insureds in Kentucky, New Jersey, New York, Ohio, and Pennsylvania

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. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

Attention: Insureds in Louisiana, Maine, Tennessee, Virginia, and Washington

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.

Attention: Insureds in Oregon

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Attention: Insureds in Puerto Rico

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

SIGNATURES

The undersigned Authorized Representative represents that to the best of his or her knowledge and belief, and after reasonable inquiry, the statements provided in response to this Application are true and complete, and may be relied upon by Travelers as the basis for providing insurance. The Applicant will notify Travelers of any material changes to the information provided.

Electronic Signature and Acceptance – Authorized Representative*

*If electronically submitting this document, electronically sign this form by checking the Electronic Signature and Acceptance box above. By doing so, the Applicant agrees that use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes acceptance and agreement as if signed in writing and has the same force and effect as a signature affixed by hand.

Authorized Representative Signature: X	Authorized Representative Name and Title:	Date (month/dd/yyyy):
Producer Name (required in FL & IA): X	State Producer License No (required in FL):	Date (month/dd/yyyy):
Agency:		Agency Phone Number:

INSURANCE AGENT OR BROKER MUST COMPLETE THE FOLLOWING:

Submitting agency name: _____ Direct Sub-produced

Address (street, city, state, zip code): _____

Phone: _____ Fax: _____ Email: _____

Licensed producer name: _____ License number: _____

ADDITIONAL INFORMATION:

In the section below you may provide additional information to any of the questions in this application. Please reference the question number.