



**PART I - AGENCY DETAILS**

1. Agency Name: \_\_\_\_\_  
 Home Office Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ Website \_\_\_\_\_
  
2. a. Does the applicant have any branch offices or subsidiaries?  Yes  No **(If yes, please attach an explanation.)**  
 b. Is the applicant firm controlled, owned, affiliated or associated with any other firm, corporation or company?  
 Yes  No **(If yes, please attach an explanation.)**  
 c. During the past 5 years has the name of the firm been changed or has any other business been acquired, merged into, or consolidated with the original firm?  Yes  No **(If yes, please attach an explanation.)**
  
3. Date Established \_\_\_\_\_  
**(If less than three years in operation, also please attach resumes of key personnel.)**  
 a. If applicable, date Applicant was first licensed as a Property/Casualty Agent or Broker \_\_\_\_\_  
 Number of years of experience as a licensed Property/Casualty Agent or Broker \_\_\_\_\_  
 b. If applicable, date Applicant was first licensed as a Life/Health Agent or Broker \_\_\_\_\_  
 Number of years of experience as a licensed Life Insurance Agent or Broker \_\_\_\_\_  
 Number of years of experience as a licensed Health Insurance Agent or Broker \_\_\_\_\_
  
4. Total number of personnel for each category:  

Full Time	Part Time	
_____	_____	Licensed Agents and Brokers (employees & principals)
_____	_____	Licensed Agents and Brokers (independent contractors)
_____	_____	Clerical
_____	_____	Other (please specify _____)

**PART II - AGENCY OPERATIONS**

5. Please give the approximate percentage breakdown of the total of your premium volume and fees as:  
 "Retail Agent" \_\_\_\_\_% (Business placed directly with insurance companies, JUA's or assigned risk pools, etc.)  
 "Retail Broker" \_\_\_\_\_% (Business placed through other agents, MGA's, wholesalers, etc.)  
 "Wholesale Broker" \_\_\_\_\_% (Business received from other non-employee or contract brokers or agents and placed by your agency.)  
 "Other" (explain) \_\_\_\_\_% \_\_\_\_\_  
**Must total 100%**
  
6. Do you derive income from any activity/profession other than the sale of insurance products?  Yes  No  
**(If yes, please attach an explanation including the percentage of your total annual income derived from it.)**
  
7. Do you currently act or have you acted in the past five years as an MGA, Third Party Administrator, Reinsurance Intermediary, or provided services for a fee as a Risk Manager/Consultant?  Yes  No  
**(If yes, please attach an explanation including the percentage of your total annual premium volume derived from it.)**

**PART III - PREMIUM VOLUME INFORMATION**

8. List ALL Insurance Companies with which your Agency places business: (Use attachment if necessary.)
- | Insurance Company | Direct Placement?  | Total Annual Premium Volume | AM Best Rating | Admitted Carrier   |
|-------------------|--|-----------------------------|----------------|--|
| _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                       | _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                       | _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                       | _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                       | _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                       | _____          | <input type="checkbox"/> Yes <input type="checkbox"/> No |

9. Are there any insurance carriers with which agency contracts have been terminated in the last 5 years and with which 25% or more of your annual premium was placed.  Yes  No **(If Yes, attach an explanation for each termination.)**

10. Breakdown of annual written premium volume by line of coverage, and gross receipts if applicable as of this date \_\_\_\_/\_\_\_\_/\_\_\_\_.

**By signing this application, the Applicant represents that the written premium figures, and gross receipts if applicable provided in question 10 are an accurate reflection of written premium at the time of signing the application. The Applicant further agrees to provide, at the Company's request, full disclosure of the agency's books and records for premium audit purposes. If an audit reveals a material change in premium than stated on the application, then the company is entitled to collect additional earned premiums, cancel or rescind coverage.**

10a. **PERSONAL LINES:**

Automobile - Standard	Volume	_____
Automobile - Non-standard (including Assigned Risk, JUA'S, etc.)	\$	_____
Homeowners - Standard	\$	_____
Homeowners - Non-standard (including Fair Plans)	\$	_____
Personal Umbrella	\$	_____
Other (describe):	\$	_____
<b>TOTAL PERSONAL LINES</b>	\$	_____

Trusts including Workers Compensation	_____
Trusts, MET's, MEWA's, etc	\$ _____
Risk Retention Plans	\$ _____
Crop / Hail	\$ _____
Other (Describe)	\$ _____
<b>TOTAL COMMERCIAL LINES</b>	\$ _____

10b. **COMMERCIAL LINES:**

Workers Compensation	\$	_____
Long Haul Trucking	\$	_____
Commercial Auto (including Livery)	\$	_____
Commercial General Liability	\$	_____
BOP (Businessowners policy)	\$	_____
Commercial Property	\$	_____
Ocean/Wet Marine	\$	_____
Inland Marine	\$	_____
Bonds	\$	_____
Aviation	\$	_____
Commercial Umbrella / Excess	\$	_____
Physicians & Hospitals	\$	_____
Professional Liability	\$	_____

10c. **LIFE/ACCIDENT/HEALTH LINES:**

Life, Individual	\$	_____
Life, Group	\$	_____
Accident, Disability & Health, Individual	\$	_____
Accident, Disability & Health, Group	\$	_____
<b>TOTAL LIFE/ACCIDENT/HEALTH LINES</b>	\$	_____
<b>TOTAL ALL LINES</b>	\$	_____

10d. **INVESTMENT INCOME**

List total gross receipts for the past twelve months for the following activities:

Fixed Annuities	\$	_____
Variable Annuities	\$	_____
Mutual Funds	\$	_____
Stocks	\$	_____
Bonds	\$	_____
Commodities	\$	_____
Financial Plans for a Fee	\$	_____

**ONLY ANSWER QUESTIONS #11-14 IF VOLUME IS LISTED UNDER QUESTION #10c (LIFE/ACCIDENT/HEALTH LINES).**

11. How many times in the past 12 months have you replaced an existing Life Insurance policy with a new policy? \_\_\_\_\_  
 Why were these policies replaced? \_\_\_\_\_
12. Is applicant involved in the ownership, formulation, creation, administration, or operation of any self-insurance fund or program, Multiple Employer Trust, Multiple Employer Welfare Arrangement, pool, syndicate, association or other combination formed for the purpose of providing insurance or benefits when they are not fully funded by an insurance product?  
 Yes     No    If Yes, advise details \_\_\_\_\_
13. If you place or service any Group Life, Accident or Health insurance, what is the largest plan (based on number of participants) that you handle? \_\_\_\_\_
14. Is the applicant a captive agent?     Yes     No  
 Is applicant employed by any insurance company?     Yes     No    If yes to either, please answer the following.  
 a. Please list the name of this company: \_\_\_\_\_  
 b. Is professional liability already provided for business placed with this company?     Yes     No

**ONLY ANSWER QUESTIONS #15-18 IF INCOME IS LISTED UNDER QUESTION #10d (INVESTMENT INCOME).**

15. Do you have discretionary control of any clients' assets?     Yes     No  
 If yes, indicate the number of clients and the value of assets controlled: \_\_\_\_\_
16. Are you involved in the sale of structured settlement annuities?     Yes     No
17. Do you have any involvement in the development or solicitation of general or limited partnerships?     Yes     No  
 If yes, provide full details: \_\_\_\_\_
18. What percentage of the premium volume listed in question 10 is written on a non-admitted basis? \_\_\_\_\_  
 (Do not include Assigned Risk, JUA'S, and Fair Plans)

19. a Does the Total Insured Value of any Commercial Property or Inland Marine account written by the applicant exceed one million dollars (\$1 million)?  Yes  No **(If yes, please attach a list of accounts including the total insured value.)**
- b Do any classes of business account for over 10% of the applicant's commercial premium volume?
- Bars/ Taverns/ Restaurants  Yes  No
- Contractors  Yes  No
- Other (please specify)  Yes  No \_\_\_\_\_

**PART IV - CLAIM 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.

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

**PART V - INSURANCE COVERAGE INFORMATION**

22. Has any prospective insured ever had their license revoked or suspended or been fined or disciplined in any way or been the subject of any investigation by any state insurance department?  Yes  No **(If yes, please attach an explanation.)**
23. During the past five years, has any director, officer, partner, employee, or independent contractor ever been declined, cancelled or refused renewal of their fidelity or surety bond?  Yes  No  
If yes, provide full details: \_\_\_\_\_
24. Has any policy of or application for similar insurance on your behalf or on the behalf of any of your principals, officers, employees, or on behalf of any predecessors in business ever been declined, canceled, or renewal refused?  Yes  No **(If yes, please attach an explanation.)**

25. Please provide the following information on your professional liability insurance for the past three years:

Name of Insurer	Limit	Deductible	Policy Period	Premium
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

26. Retroactive Date of current policy (if any): \_\_\_\_/ \_\_\_\_/ \_\_\_\_
27. Have you ever purchased "Extended Discovery/Reporting Period" coverage ("tail") from any prior insurer?  Yes  No **(If yes, please attach an explanation.)**

**FRAUD STATEMENT:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

The undersigned declares that to the best of his/her knowledge and belief the statements set forth herein are true, The undersigned further declares that any occurrence or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Insurer and the Insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the policy.

**Signature of Applicant or Insured:** \_\_\_\_\_ Must be signed by a Principal, Partner or Officer of the Firm

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