

Renewal Application for Lawyers Professional Liability Insurance Policy



AMERICAN GUARANTEE AND LIABILITY INSURANCE COMPANY

THIS APPLICATION IS FOR A CLAIMS-MADE AND REPORTED POLICY.
IF ISSUED, PLEASE READ YOUR POLICY CAREFULLY.

Please type or print clearly in ink. Answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplements. IF YOU HAVE A CLAIM OR CIRCUMSTANCE THAT COULD RESULT IN A CLAIM IMMEDIATELY REPORT IT TO ZURICH, call 1-800-987-3373.

Current Policy Number: _____

Expiration Date: _____

Applicant's Name: _____

CURRENT COVERAGE	DESIRED COVERAGE
Limit _____ Amount Each Claim/Aggregate	Limit \$ _____ Amount Each Claim/Aggregate
Deductible _____	Deductible \$ _____

- Has the Applicant's name, principal address, telephone number, facsimile number, e-mail address or web site changed? Yes No
If Yes, please provide a copy of the new letterhead and the modified information.
- Has there been a change in the number(s) and/or name(s) of Attorneys since the last application? Yes No
If No, do not complete the chart below.

Please list all Attorneys working for Applicant (include yourself if you are a sole practitioner) in the chart below. If necessary, please continue on a separate page.

Attorney Name	D.C.*	Date of Birth (mm/dd/yy)	Number of Years in Practice	Date of Hire (mm/dd/yy)	Number of Hours Worked/Week	Attorney Bar Number	Indiv Retro Date

*Designation Codes
O-Officers, Directors, Shareholders of the corporation who are licensed attorneys **S**-Sole Practitioner
P-Partner, if a Partnership **E**-Employed Attorney
C-Of Counsel Attorney **IC**-Independent Contractor
PT-Part-Time Attorney (must practice law fewer than 26 hours per week solely for applicant firm)

AREAS OF PRACTICE

- Have the Applicant's areas of practice or percentages changed since the last application? Yes No
If No, do not complete the chart below.

Instructions for completing this section:

- Based upon the last fiscal year please provide the percentage of time devoted (number of hours actually worked) to each area of practice listed in the chart below.
- If the Applicant indicates work for any areas of practice designated below in capital letters, please request and complete the applicable Supplemental Forms.
- Does the Applicant's practice involve any Attorney acting in the capacity of a mediator or arbitrator? Yes No
If Yes, indicate the percentage of time devoted to acting as a mediator or arbitrator. This percentage must be allocated to an area or areas of practice in the chart below. _____ %

AREAS OF PRACTICE cont'd...

Area of Practice	Expiring %	Projected %	Area of Practice	Expiring %	Projected %
Admiralty/Maritime			Government (Federal/State/Local/Lobbying)		
Antitrust/Trade Regulation			Healthcare		
Aviation			Immigration		
Bankruptcy			Insurance Defense Litigation		
Business Transactions/Commercial Law			Insurance Other (Coverage, Regulatory, Subrogation)		
Civil Rights			International Law		
COLLECTIONS			Investment Counseling/Money Management		
Commercial Practice – Business Litigation			Labor – Union Related Work		
Communications/Media			Medical Malpractice – Defendant		
Construction Law			Medical Malpractice – Plaintiff		
Consumer Claims			Oil/Gas		
COPYRIGHT/TRADEMARK			PATENT		
Corporate – Business Formation/Alteration			Personal Injury – Defendant		
Corporate – Business Transactions/Advice			Personal injury – Plaintiff		
Criminal Law			Public Utilities		
Disability/Social Security			REAL ESTATE – Commercial		
Elder Law			REAL ESTATE – Residential		
Employment			Secured Transaction (UCC – Commercial Paper)		
ENTERTAINMENT			SECURITIES LAW (except corporate formation)		
ENVIRONMENTAL			Taxation		
Estates/Wills/Trust/Probate			Tax Shelters		
Family Law			Workers' Compensation – Defendant		
Financial Institutions-Reg. Compliance			Workers' Compensation – Plaintiff		
			TOTAL (must equal 100%)		%

4. If the Applicant has stated any percentage of Medical Malpractice - Plaintiff work in the Areas of Practice chart, please indicate in percentages, the amount of work allocated to the following areas:

Nursing Homes	%	OB/GYN	%	Oncology	%	Pediatrics	%
Permanent Disability	%	Wrongful Death	%	Other*	%		

*If the Applicant stated a percentage of work for "Other", please explain the type of work performed on a separate sheet.

5. Does the Applicant engage in any Class Action/Mass Tort work? Yes No
If Yes, please complete the applicable Supplemental Form.

6. Does the Applicant expect any changes to its areas of practice in the next 12 months? Yes No
If Yes, please explain on a separate sheet of paper and specifically indicate the new areas of practice expected to be handled by the Applicant.

RISK MANAGEMENT

7. Have there been any changes in the Applicant's risk management practices since the last application? Yes No
If Yes, please request and complete the Risk Management Supplemental Form.

8. Has your firm filed for bankruptcy or had any liens or suits pending against it since the last application? Yes No

9. Does the Firm or any attorney currently own or rent its primary office location? Own Rent

LOSS HISTORY

If the answer is Yes to any of the following questions, please request and complete the Notice of Circumstance/Claim Reporting Form and attach additional sheets as necessary.

- 10. Has any Attorney in Question 2 or employee of the Applicant been the subject of a criminal action, a reprimand, disciplinary action, Bar complaint, investigation, or other ethics proceeding within the past year? If Yes, please provide a copy of the dismissal or action documents or letter from the Bar. Yes No
- 11. Has any claim or suit arising out of the rendition of legal services been made against any Attorney in Question 2 or employee of the Applicant within the past year? Yes No
- 12. Is any Attorney in Question 2 or employee of the Applicant aware of any circumstance(s), incident(s), act(s), error(s) or omission(s) that could result in a claim or suit against the Applicant or any predecessor or any of the former or current members or employees of the Applicant? Yes No

Please note that if the responses to questions 10, 11 and 12 are in the affirmative, you must immediately report the claim or circumstance that could result in a claim to Zurich at 1-800-987-3373.

By signing this application the undersigned agrees that after inquiry of all prospective insureds, no person proposed for coverage is aware of any fact or circumstance which reasonably might give rise to a future claim that would fall within the scope of the proposed coverage.

Receipt and review of this application does not bind the insurer to provide this insurance.

It is agreed by the undersigned and the insurer that the particulars and statements made in this application, together with all attachments to this application and any other materials submitted to the insurer (all of which attachments and materials shall be deemed attached to the policy as if physically attached thereto) shall be the representations of the undersigned and the prospective insureds. It is further agreed by the undersigned and the prospective insureds that this policy, if issued, is issued in reliance upon the truth of such representations that are incorporated into and made part of this policy. After inquiry of all prospective insureds, the undersigned represents that the statements set forth in this application and its attachments and other materials submitted to us are true and correct. Signing of this application does not bind the undersigned or the insurer.

If the applicant has concealed or misrepresented any material fact, circumstance or fraud concerning this insurance resulting in deception to us which existed at the time of damage and contributed to such damage, this policy will be rendered void as long as the deception was material; was made knowingly with the intent to deceive; was relied and acted upon by the Insurer; and deceived the Insurer to the Insurer's injury.

The undersigned further declares that any event taking place between the date this application was signed and the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any information in this application, will immediately be reported in writing to us and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Fraud Notice to Washington 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.

Completion of this form does not bind coverage. The undersigned's acceptance of company's quotation is required prior to binding coverage and policy issuance. It is agreed that this application shall be the basis of the contract of insurance should a policy be issued and it will be attached to the policy.

Signature: _____ **Date:** _____
Principal, Partner or President

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____
Agent

NOTE: THIS APPLICATION MUST BE SIGNED BY A PRINCIPAL, PARTNER OR PRESIDENT OF THE FIRM ACTING AS THE AUTHORIZED AGENT OF THE APPLICANT.

Disclosure Statement



DISCLOSURE OF COMPENSATION

Daniels-Head Insurance Agency, Inc. is a licensed insurance agency representing Zurich. This notice is provided to advise you about the compensation we receive for our services. We are compensated by Zurich for placing policies with Zurich and for providing service to customers on those policies.

We hope this information is helpful. Thank you.