

Supplemental Application for Architects & Engineers Professional Liability Coverage

Principal Firm Name:

Policy Term:

The information provided herein is considered material to our underwriting and pricing decision for the policy or additional coverage under consideration at the time this supplemental application is submitted.

KNOWLEDGE OF CLAIMS OR INCIDENTS

1. Have any claims been made or legal action been brought in the past ten years (or made earlier and still pending) against your firm, its predecessor(s) or any past or present principal, partner, officer, director, shareholder or employee? Y N

If yes, provide the following information for each claim on a separate sheet:

- | | |
|-------------------------------|---|
| a. Date of claim | e. Insurance company reserve, if any |
| b. Claimant or Plaintiff | f. Defense attorney's or insurance company's evaluation of exposure/potential liability |
| c. Allegations | g. Defense and Indemnity Paid to Date and Status (open/closed) |
| d. Demand or amount of claims | h. Deductible applicable |

2. After complete investigation and inquiry, do any of the principals, partners, officers, directors, members, shareholders, employees, or insurance managers have knowledge of any act, error, omission, fact, incident, situation, unresolved job dispute (including owner-contractor disputes), accident, or any other circumstance that is or could be the basis for a claim under the proposed insurance policy? Y N

If yes, on a separate sheet please give details of this situation, including name of project and claimant, dates, nature of situation and amount of damages.

3. Please indicate the coverage request being made in conjunction with this supplemental application:

- | | |
|---|---|
| <input type="checkbox"/> New Policy Effective: | <input type="checkbox"/> Renewal Policy Effective: |
| <input type="checkbox"/> Full Prior Acts Coverage | <input type="checkbox"/> Limited Prior Acts—Acts performed on or after: |
| <input type="checkbox"/> Increased Limits | from to Reason for increase: |
| <input type="checkbox"/> Deductible Change | from to Reason for change: |
| <input type="checkbox"/> Reinstatement of Lapsed Coverage—Date coverage lapsed: | Reason for lapse: |
| <input type="checkbox"/> Other—Describe: | |

Report knowledge of all such incidents to your current carrier prior to your current policy expiration.

If this supplemental application is submitted in conjunction with an application for a **new policy** the policy of insurance being applied for will not respond to incidents about which you had knowledge prior to the effective date of the policy or the date this supplemental application was signed, whichever is later, nor will coverage apply to any claim or incident identified or that should have been identified in Questions 1 and 2 of this supplemental application.

If this supplemental application is submitted in conjunction with a **request to renew a policy or reinstate a policy that has lapsed**, the renewed or reinstated policy of insurance will not respond to incidents about which you had knowledge prior to the effective date of the renewed or reinstated policy or the date this supplemental application was signed, whichever is later. No coverage will apply, under the renewed or reinstated policy, to any claim or incident identified or that should have been identified in Questions 1 and 2 of this supplemental application, if coverage would not apply but for the renewed or reinstated coverage provided on the basis of representations made in this supplemental application.

If this supplemental application is submitted in conjunction with **additional or expanded coverage**, the additional or expanded coverage being applied for will not respond to incidents about which you had knowledge prior to the effective date of the additional or expanded coverage or the date this supplemental application was signed, whichever is later, nor will the additional or expanded coverage apply to any claim or incident identified or that should have been identified in Questions 1 and 2 of this supplemental application.

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 or incomplete 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 District of Columbia residents only: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.) (For Florida residents only: 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.) (For Louisiana residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) (For Maine residents only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.) (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 Oklahoma residents Only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) (For Pennsylvania residents only: 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.) (For Puerto Rico residents only: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousands dollars (\$5,000) nor more than ten thousands dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (For Washington residents only: 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.)

REPRESENTATION

Applicant represents on its behalf and on behalf of each and every partner, officer, director, member, stockholder, employee and manager that the person completing this application has the authority to do so on behalf of the applicant, and that after full investigation and inquiry, 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. Further, it is understood and agreed that the completion of this application does not bind the insurance company to sell nor the applicant to purchase the insurance.

Applicant further acknowledges on its behalf and on behalf of each and every partner, officer, director, member, stockholder, employee or insurance manager:

1. A continuing obligation to report to the Company immediately 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;
2. If a policy is issued, the Company will have relied upon as representations: the 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. This application will be the basis of the contract and will be incorporated by reference into and made part of such policy.

Name of Principal, Partner or Officer: Mr. Mrs. Ms.
(Please Type or Print)

Title:

Signature: (Principal, Partner or Officer) _____

Date:



Signature: (Insurance Agent) _____

Date:

NOTE: This supplemental application must be reviewed, signed and dated within a month of submission by a principal, partner or officer of the applicant firm.



Underwriting Managers and Program Administrators

Two Wisconsin Circle, Chevy Chase, MD 20815

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