



Wesco Insurance Company
 800 Superior Ave East
 21st Floor
 Cleveland, OH 44114

NOTICE: THE POLICY FOR WHICH YOU ARE APPLYING PROVIDES COVERAGE ON A CLAIMS MADE AND REPORTED BASIS AND IS LIMITED TO ONLY THOSE CLAIMS WHICH ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD.

**WESCO INSURANCE COMPANY
 INSURANCE AGENTS AND BROKERS ERRORS AND OMISSIONS APPLICATION**

Section I

1. Agency Name:
 Policy Number:
 DBA (if applicable):
 Physical Address:
 City: State: County: Zip Code:
 Phone No.:

2. Is the Agency: A

3. What percent (%) of your business is: **(TOTAL MUST EQUAL 100%)**

- Retail (Business Sold Directly To Insureds) %
 Wholesale (Business Sold To Other Agents) %
 MGA (Business For which You Have Underwriting Authority) %

4. a.) Year Agency/Entity Established: b.) Year Current Owner(s) Assumed Management

***Resumes for all agency officers/owners/brokers and agents must be provided if agency established within the past 3 years.**

c.) Number of Agency Personnel

(only include each person in one category)	# of Persons	Avg. # of Years in Insurance
Owners, Principals, Partners, Members		
Employed, Licensed Brokers & Agents		
Commission Only Producers/Solicitors		
Number of Licensed Staff including CSR's		
Unlicensed Staff/Clerical		

5. Percentage of Business Placed With Admitted Carriers: % Non Admitted/Surplus Lines Carriers: %
 6. Percentage of Business Placed: Direct Through Carriers: % Through MGAs: % Through Wholesalers: %
 7. Percentage of Business Placed with Carriers Not Rated or Rated Less than B+ by A.M. Best **0** %

8. Please provide for last 12 months: (Enter as whole numbers only. 10,000 is entered as 10000. 1,000,000 is entered as 1000000.)

Total Commercial Lines Premium Volume		Commercial Lines Gross Commission Income	
Total Personal Lines Premium Volume		Personal Lines Gross Commission Income	
TOTAL P & C PREMIUM VOLUME		TOTAL Life/ A & H COMMISSION	
TOTAL FEE INCOME or OTHER INSURANCE RELATED ACTIVITIES		TOTAL GROSS COMMISSION LAST 12 MONTHS	
		IF MGA/ MGU OR WHOLESALER - NET COMMISSION INCOME	

9. Breakdown of agency business

(Totals should equal Gross Income for retailers or Net Income for MGA/Wholesale stated in Question 8 above).

	COMMERCIAL LINES		PERSONAL LINES		LIFE & HEALTH
%	Workers Comp.	%	Automobile Standard	%	Life
%	Commercial Auto (except trucking)	%	Automobile (Non Standard)	%	Health & Accident
%	Trucking (Fleet and/or Long Haul)	%	Umbrella	%	Annuities & Pension
%	Commercial Multi Peril	%	Property & Dwelling	%	Other
%	Bonds	%	Other (Specify)		
%	Professional Liability				
%	Directors & Officers Liability				
%	Medical Malpractice				
%	Energy / Pollution / Environmental				
%	Umbrella/Excess				
%	Aviation				
%	Wet Marine				
%	Crop				
%	Liquor Liability				
%	Other (Specify)				
%	TOTAL COMMERCIAL LINES	%	TOTAL PERSONAL LINES	%	TOTAL LIFE & HEALTH

TOTAL ALL LINES: %
(Must Total 100%)

10. Does the applicant or any agency owner, officer, partner/principal, member of solicitor or employee perform any of the following activities? If yes, attach resume, promotional material and sample contract. Coverage may be excluded under the policy

	YES	NO	Income		YES	NO	Income
Reinsurance Intermediary				Human Resources			
Third Party Administrator				Actuarial Services			
Claim Adjustment Services				Tax Advisor			
Risk Management/Loss Control				Premium Finance for Agency Clients			
Investment, Securities Advisor				Real Estate			
Prepaid Legal Services				Other			

11. What is the next 12 months estimated: \$ Premium Volume: \$
 Gross Commission Income? \$

12. Do you expect major changes in the lines of business written in the next 12 months? Yes No

If yes, please provide details:

Section II

Does the Applicant act as Managing General Agent, Wholesale Broker, Underwriting Manager and/or Program Administrator?

Yes No If NO, skip to Section III.

If Yes, please complete the following:

1. Provide the following information for each company/carrier that you have represented

Name of Companies / Carriers Represented with Binding Authority	Years Under Contracted (state as 19xx-2xxx)	Annual Premium Volume	# of Audits Per Year	# of Producers Appointed as Sub-Agents

2. What is the Applicant's Maximum Authority for the following:

Binding Risks: \$ Claims Adjusting: \$
 Loss Control: \$ Reinsurance Placement: \$

3. In the last five (5) years has a Program / Contract been cancelled or terminated? Yes No

4. Has a Company/Carrier added restrictions to the applicant's underwriting or claim handling authority?

Yes No If Yes to either question 3 or 4, please provide details:

5. If you accept business from sub-agents, do you require evidence of Professional Liability coverage?

Yes No N/A

If Yes, What limits are required?

How many sub-agents have binding authority?

Section III

1. Does the applicant have any subsidiaries or affiliated organizations? Yes No

2. a. Have you acquired any agencies in the past 12 months? Yes No

If Yes, provide the following for each subsidiary and affiliated organization.

b. Is coverage requested for any of the above subsidiaries or affiliated organizations? Yes No

If Yes provide endorsement(s) for additional named insureds from expiring coverage.
 Please confirm all premium volume and income for all subsidiaries or affiliated organizations to be included in coverage are included in questions 8 and 9 above.

3. Office Procedures:		YES	NO	N/A
a.	Does the agency utilize a computerized production and accounting system?			
b.	Is there a back-up procedure for computerized production?			
c.	Are written or electronic records maintained outlining details of all business conversations, including client's verbal instructions and oral agreements?			
d.	Are insured requests for changes, cancellation of coverage or rejection of coverage, required in writing, signed and dated?			
e.	For all policies that are renewed with less coverage than on the expiring policy, are signed and dated reduced coverage statements acknowledging the reduction of coverage obtained?			
f.	Does the agency receive written declination from the client if they decline to purchase hurricane, flood and/or windstorm coverage? If not Yes, provide details			
g.	Is a policy expiration list maintained?			
h.	Are all incoming documents date identified?			
i.	Does the agency have a written office procedures manual?			
j.	Are all applications, policies and endorsements checked for accuracy?			
k.	Do you use Power of Attorney to represent your insureds? If Yes, provide details			
l.	Are files marked to ensure certificate holders are notified of cancellation or material changes?			
m.	Do you obtain written confirmation when reducing or eliminating coverage from your clients?			
n.	Does your agency have a Commercial Crime Policy?			
o.	Does your agency have a General Liability Policy?			
p.	Does 20% or more of management, including Office Manager, annually attend a Risk Management Seminar sponsored or approved by AmTrust Financial Services, or State Program Loss Prevention Seminar?			

4. In the past 5 years, please provide the number of E&O claims / incidents made against the applicant or any past or present owner, officer, partner, principal, employee, member, solicitor or independent contractor

0 1 2 3 or more

Please complete a claim supplement for each claim / incident and provide current (within 60 days) loss runs.

5. Has the applicant or any past or present owner, member, partner, director, officer, employee or independent contractor been the subject of a disciplinary action, investigation, license suspension or fine as a result of professional services?

Yes No **(If Yes, please provide details below)**

6. Does the applicant or any owner, partner, director, officer, employee or independent contractor have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim?

Yes No **If Yes have you reported to your current E&O carrier?** Yes No

(If Yes, please provide details)

7. Has the applicant ever had E&O coverage declined, canceled or refused renewal? (Not applicable for MO applicants)?
Yes No **If yes, provide an explanation below**

8. Does the applicant have any additional named insureds or additional insureds endorsed on current coverage?
Yes No **If Yes, please provide endorsement(s) from expiring coverage.**

9. Do you currently have Errors & Omissions Insurance in force? Yes No Expiration Date:
Name of Insurance Carrier:
Current Limits: \$ Deductible: \$
Retro Date: Premium \$: (Attach a copy of Expiring Declaration page)

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or another 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 may be a crime and may subject the person to criminal penalties.

ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO, RHODE ISLAND, VIRGINIA and WEST VIRGINIA: 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. In Alabama, Arkansas, Louisiana, Rhode Island and West Virginia that person may be subject to fines, imprisonment or both. In New Mexico, that person may be subject to civil fines and criminal penalties. In Virginia, penalties may include imprisonment, fines and denial of insurance benefits.

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.

DISTRICT OF COLUMBIA, KENTUCKY 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 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. In District of Columbia, penalties include imprisonment and/or fines. In addition, the Insurer may deny insurance benefits if the Applicant provides false information materially related to a claim. In Pennsylvania, the person may also be subject to criminal and civil penalties.

FLORIDA and OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive the Insurer, files a statement of claim or an Application containing any false, incomplete or misleading information is guilty of a felony. In Florida it is a felony to the third degree.

KANSAS: an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

MAINE: 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 denial of insurance benefits.

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

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal or civil penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Insurer, submits an Application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OREGON: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE 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 may include imprisonment, fines and/or denial of insurance benefits.

NOTICE TO APPLICANT – PLEASE READ

CAREFULLY BEFORE SIGNING

THE APPLICANT AND AGENCY ACCEPTS NOTICE THAT ANY POLICY ISSUED WILL APPLY ON A "**CLAIMS-MADE AND REPORTED**" BASIS. The undersigned is authorized by and acting on behalf of the Applicant and represents that all statements and particulars herein are true, complete and accurate and that there has been no suppression or misstatements of fact and agrees that this application shall be the basis of coverage.

THE APPLICANT:

1. Understands and agrees this Application and any and all supplements, attachments and replies to underwriter inquiries are made a part of and incorporated into any policy issued, and any such policy will be issued in reliance upon the representation(s) made herein. Applicant further understands and agrees that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued;
2. Authorizes and consents to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of Applicants business including authorization to every person or entity, public or private, to release to the Company providing insurance coverage any documents, records or other information bearing upon the foregoing; and
3. Understands and agrees these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

THE APPLICANT AND FIRM ACCEPTS NOTICE THAT THEY ARE REQUIRED TO PROVIDE WRITTEN NOTIFICATION TO THE COMPANY OR ANY CHANGES TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE. THE APPLICATION MUST BE SIGNED BY AN ACTIVE OWNER, PARTNER, PRINCIPAL, OFFICER OR MEMBER OF THE APPLICANT.

Date

Signature

Printed Name Signature

Title of Person Signing the Application

SIGNING THIS FORM OR TENDERING PREMIUM WITH THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE.