



Computer Consultants Supplemental

APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

Applicant's Name: _____ Date: _____

1. Please briefly describe the primary computer services for which coverage is desired:

2. Please indicate the percentage of Applicant's annual revenue from the last fiscal period involving:

Advise details next to each item which may help in understanding Applicant's operations.

Training and Education	_____ %	_____
Records Management/ Retrieval	_____ %	_____
Hardware Maintenance Services	_____ %	_____
Package Software Installations	_____ %	_____
Graphics/ Presentation Materials	_____ %	_____
Basic Computer Security	_____ %	_____
Computer Security (High Tech)	_____ %	_____
Custom Software Development	_____ %	_____
Equipment Evaluation & Selection	_____ %	_____
EDP Audit	_____ %	_____
Needs Evaluation	_____ %	_____
Packaged Software Development/Sales	_____ %	_____
Hardware Manufacturing/Sales	_____ %	_____
Web Site Design	_____ %	_____
Other	_____ %	_____
Total (must equal 100%)	_____ %	Gross receipts from these activities last year \$ _____

3. Does the Applicant provide any services other than those services listed above in #2? Yes No
If yes, please provide details on a separate sheet.

4. Is the Applicant an Internet Service Provider and/or does it provide any internet access, online publishing, and/or services as a web portal, web host, web search engine, e-mail service, chat room, online database or bulletin board? If "Yes" please provide details on a separate sheet and % of receipts. Yes No % Receipts _____

5. Does the Applicant provide any consulting services which **enable or affect any of the following?** (Please provide details below).

	Yes	No	%Receipts
CAD/CAM design or control, robotics or process control of industrial equipment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mechanical, electrical, chemical, civil or architectural design or engineering?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fund transfers or financial transactions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aircraft, air-ground equipment, military defense and/or weaponry of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medical, dental or healthcare diagnosis, monitoring or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharmaceutical formulation, production or prescriptions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
911 or other emergency response and/or dispatch?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Energy, power plant, utility or pollution monitoring, supply or distribution?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Computer security services intended to protect financial assets or privileged government information not intended for public usage/ consumption?	<input type="checkbox"/>	<input type="checkbox"/>	_____

THIS COMPUTER CONSULTANTS SUPPLEMENTAL APPLICATION IS ATTACHED TO AND FORMS PART OF THE PROFESSIONAL LIABILITY APPLICATION. THIS SUPPLEMENTAL APPLICATION IS SUBJECT TO THE SAME PROVISIONS CONCERNING REPRESENTATIONS MADE IN THE BASIC APPLICATION.

SIGNATURE TITLE DATE

CONSULTANTS AND SPECIFIED PROFESSIONS PROFESSIONAL LIABILITY APPLICATION

APPLICATION

ALL QUESTIONS MUST BE ANSWERED AND APPLICATION MUST BE SIGNED BY APPLICANT.

THIS IS AN APPLICATION FOR A CLAIMS MADE POLICY. PLEASE READ YOUR POLICY CAREFULLY.

SECTION I: BACKGROUND INFORMATION

1. Name of Insured: _____
2. Address: _____
City: _____ State: _____ Phone: _____
Website: _____
3. Date Established: _____
4. Is the Applicant controlled, owned, affiliated or associated with any other firm, corporation or company? Yes No
5. Does the Applicant have any Subsidiaries? Yes No If Yes, please list on a separate sheet and advise if coverage is to apply to them.
6. Applicant is: Corporation Partnership Individual

SECTION II: ORGANIZATION OPERATIONS DETAILS

7. Please describe in detail the professional services for which coverage is desired:

8. (a) List total gross receipts derived from activities in question #7:

	Gross Receipts
Last Year:	\$ _____
Current Year(based on 12 months):	\$ _____
Forecast for Next Year:	\$ _____
- (b) Please indicate the percent of receipts listed in 8a from Foreign Operations (i.e. outside of the U.S. and its territories): _____
- (c) Did the Applicant have a positive net income in the past 12 months? Yes No
If No, please advise net income and steps being taken to correct the negative net income.
- (d) What is the Applicant's overall net equity? _____ Positive Negative
If Negative, please advise net equity and steps being taken to correct the negative net equity.
9. (a) Describe the 5 largest jobs or projects during the past 3 years

Name of Client	Services Provided	Gross Billings
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
- (b) Does the Applicant anticipate deriving more than 50% of total gross billings for the coming year from a single client?
 Yes No If Yes, advise details on a separate sheet.
10. Is the Applicant a licensed Professional(i.e. Lawyer, Accountant....)? Yes No
If Yes, advise type of licensed Professional: _____
11. (a) Number of principals, partners, officers and professional employees directly engaged in providing services to clients: _____
(b) Number of non-professional employees (clerks, secretaries, etc.): _____
(c) Number of independent/sub contractors: _____

12. Please answer the following question(s) regarding the use of independent contractors.
- (a) Does the Applicant desire to provide coverage solely for themselves with respect to liability arising out of work performed by independent contractors? Yes No; or
- (b) Does the Applicant desire to provide coverage for independent contractors (including them as named insured(s) on your policy), while working on your behalf? Yes No If Yes to 12b, please answer the following questions:
- (1) How will the Applicant utilize each independent/subcontractor? _____
- (2) The total percent of Applicant's work done by independent/subcontractor. _____
- (3) Does the Applicant require Certificates of Professional Liability Insurance from all independent contractors? Yes No

13. Please provide the following:

Name of Partners, Principals, Key Employees and Independent/ Subcontractors	Professional Qualifications/ Designations	# of Years in Practice
_____	_____	_____
_____	_____	_____
_____	_____	_____

14. Does any director, officer, employee, partner or independent/subcontractor of the Applicant serve on the Board of Directors of any client or own any financial or equity interest in any client of the Applicant? Yes No If Yes, attach an explanation.

15. What do you see as your potential exposure to a professional liability claim? _____

16. Does the Applicant use a written contract or letter of engagement with clients? In all cases Sometimes No

SECTION III: CLAIMS 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.

17. During the past 5 years, has any claim been made or suit brought against the Insured, its predecessor(s) in business, or any of its present or former owners, partners, officers, directors, employees or independent contractors? Yes No
 (If Yes, please provide details on a separate supplemental claim application.)

18. 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 Insured, its predecessor(s) in business, or any of its present or former partners, owners, officers, directors, employees or independent contractors? Yes No
 (If Yes, please provide details on a separate supplemental claim application.)

SECTION IV: PROFESSIONAL LIABILITY INSURANCE COVERAGE

19. Has any Policy of or Application for professional liability insurance on your behalf or on the behalf of any of your principals, officers, employees, independent contractors, or on behalf of any predecessor(s) in business ever been declined, cancelled or renewal refused? Yes No If Yes, advise details: _____

20. Is similar professional liability insurance currently in force? Yes No

Name of Carrier	Limit	Retroactive Date (if any)	Deductible	Premium	Policy Period
_____	_____	_____	_____	_____	_____

Length of time coverage has continuously been in force: _____

SECTION VI: GENERAL LIABILITY INSURANCE

21. Does the Applicant currently have General Liability Insurance? Yes No If Yes, please advise the following:

Name of Carrier	Limit	Premium	Expiration Date
_____	_____	_____	_____

22. Describe any General Liability Losses in the past 5 years: _____

23. Number of Employed Consultants/Persons rendering Professional Services as described in Question 7: _____

24. (a) Does the Applicant use Independent Contractors? Yes No If Yes, please answer 25 (b) and (c)
 (b) Is General Liability coverage to include Independent Contractors? Yes No
 (c) Number of Independent Contractors used: _____

25. Is the Applicant involved in the installation of hardware, electrical work, wiring and/or cable installation of the items for which they are providing consultation services (including work done by Independent Contractors on behalf of Applicant)? Yes No

26. Additional Insureds to be included (List name, address and relationship to Applicant): _____

SECTION VII: Personal Property Insurance

27. (a) Personal Property Limit (at 80% Coinsurance/Replacement Cost): _____

(b) EDP Equipment Limit \$ _____

(c) Burglar Alarm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Central Station	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sprinklers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Central Station	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fire Alarm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Central Station	<input type="checkbox"/> Yes	<input type="checkbox"/> No

28. Property Protection Class (1-10): _____

29. If located in first tier coastal county, distance from water (ocean, bay or inlet): _____

30. Property Claims Paid or Pending during last 5 years (by year): _____

31. Building Construction (please check one):

- Frame - Bldg. is made from a wood frame (2x4's/veneers).
- Joisted Masonry - Outside walls are constructed with bricks/cinder blocks. Roof is made of wood.
- Masonry Non-Combustible - Same as Joisted Masonry, except roof is steel.
- Fire Resistive - Structural steel framing, reinforced concrete outside/load bearing walls.

SECTION VIII: Building Insurance

If you are a building owner, please answer the following:

32. Building Address: _____

(a) Mortgagee (if applicable): _____

33. Value (at 80% Coinsurance/Replacement Cost): _____

34. Building Age: _____

(a) Is the electrical system connected to circuit breakers? Yes No

35. Square Footage: _____

SECTION IX: REQUIRED INFORMATION

A. USLI Application.

B. Copy of resumes on technical and key personnel.

TEXAS APPLICANTS: THE INSURANCE FOR WHICH YOU ARE APPLYING IS AVAILABLE TO MEMBERS OF CONSULTANTS PRORISK PURCHASING GROUP AND IS SUBJECT TO TERMS AND CONDITIONS OF THE POLICY BY UNITED STATES LIABILITY INSURANCE GROUP TO CONSULTANTS PRORISK PURCHASING GROUP UPON INCEPTION OF COVERAGE IN ACCORDANCE WITH AND SUBJECT TO ITS BY-LAWS. CONSULTANTS PRORISK PURCHASING GROUP IS A PURCHASING GROUP IN ACCORDANCE WITH THE FEDERAL LIABILITY RISK RETENTION ACT OF 1986.

FRAUD STATEMENT: 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 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.

THE STATES OF FLORIDA AND NEW YORK REQUIRE THAT WE HAVE THE NAME AND ADDRESS OF YOUR (INSURED'S) AUTHORIZED AGENT OR BROKER.

NAME OF AUTHORIZED AGENT OR BROKER _____

ADDRESS _____

LICENSE NO. _____

MAIL COMPLETED _____

APPLICATION THROUGH _____

LOCAL AGENT OR _____

BROKER TO: _____

NOTICE TO THE APPLICANT

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 Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The Company is hereby authorized, but not required to make an investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Company not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Company and shall not stop the Company from relying on any statement in this Application. The signing of this Application does not bind the undersigned to purchase the Insurance, nor does the review of this Application bind the Company to issue a policy. It is understood the Insurer is relying on 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 this Policy.

Signature of Applicant or Insured: _____

Must be signed by a Principal, Partner or Officer of the Firm

Date: _____

SUPPLEMENTAL CLAIMS APPLICATION

When any one of the Claims Questions is answered “Yes”, please complete this form for **each Claim**.

1. Name of Claimant? _____

2. When did Claim occur? _____

3. Details and background of Claim _____

4. Has the EEOC or State Human Rights Agency ruled on this case? Yes _____ No _____ .

If Yes, was ruling A. Probable Cause _____ B. No Probable Cause _____

(PLEASE ATTACH A COPY OF THE RULING).

5. What is the Status of the Claim? _____

6. Amount of Defense Costs Paid? _____

7. Settlement Amount? _____

8. Was the Claim filed with Insurer? Yes _____ No _____ If Yes, was the Claim covered by Insurance? Yes _____ No _____ .

9. If Claim is still open, what amount of Reserve has been set up by the Insurer? _____

10. What remedial measures have been taken to prevent a recurrence of a similar Claim? _____

Signature: _____ Date: _____
(By President or Chairman of Board of Insured)

The information on this supplemental Application is material to the Company underwriting this risk and shall be deemed attached a part of this Policy as if physically attached hereto.