

**WESTPORT INSURANCE CORPORATION**

150 King Street West, Suite 1000

Toronto, Ontario M5H 1J9

**APPLICATION FOR "CLAIMS MADE" AND REPORTED INSURANCE POLICY  
FOR LIFE INSURANCE BROKERAGE/AGENCY PROFESSIONAL LIABILITY (E&O)**

1. a. Name of Brokerage/Agency for which coverage is required.

\_\_\_\_\_  
\_\_\_\_\_

b. Does the agency have subsidiaries?  Yes  No **If Yes**, Provide details.

\_\_\_\_\_

c. Organization Type:  Sole Proprietor  Partnership  Corporation

d. Date entity established\*: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (month/day/year)

**\*If less than 3 years, attach resume of principle**

2. a. **Mailing Address**

\_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

b. Phone: (\_\_\_\_) \_\_\_\_\_ c. Fax: (\_\_\_\_) \_\_\_\_\_

d. E-Mail Address: \_\_\_\_\_

e. Website Address: \_\_\_\_\_

f. Does website contain a privacy statement?  Yes  No

3. a. During the last 5 years, has the name or ownership of the brokerage/agency changed?  Yes  No

b. If Yes to 3a, please complete the following questions:

Date of name or ownership change: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (month/day/year)

c. Indicate reason for name or ownership change:

Merger/Acquisition (Describe below)

Ownership Change (Describe below)

Change in Organizational status:  Incorporated  Partnership/LLC/LLP Formed

Other (Describe):

\_\_\_\_\_  
\_\_\_\_\_

	<u>Commission</u>	<u>Fees</u>
4. a. Total Brokerage/Agency gross <b>commissions</b> and <b>fees</b> written annually	\$ _____	\$ _____
b. Total Brokerage/Agency net <b>commissions</b> and <b>fees</b> written annually	\$ _____	\$ _____
c. Total Brokerage/Agency gross <b>commissions</b> and <b>fees</b> estimated next 12 months	\$ _____	\$ _____

5. a. Number of Personnel: (Each individual should be counted only once.)

	Full-Time	* Part-Time	Average Years of Insurance Experience	Average Turnover Rate
Licensed Personnel				
Non-Licensed Employees (i.e., clerical)				
<b>TOTAL STAFF:</b>				
Licensed Sub-Agents **				

**Please attach a list of all licensed personnel, including # of years with applicant, professional designations, provinces licensed and where they are currently insured.**

\* If Part-Time, please explain.

\*\*Policy does not provide coverage

b. Do you require Certificates of Insurance from **all** your sub-agents each year?  Yes  No

6. a. Breakdown of your total income by percentage of professional activities in the last year.

	Current Year	Prior Year	Activity Performed?		Revenue	Coverage Desired?	
			Yes	No		Yes	No
Life, Individual	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Life, Group	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Health, Individual	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Health, Group (Self-Insured) *	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Health, Group (Not Self-Insured)	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Annuities <b>(Fixed)</b>	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Annuities <b>(Variable)</b>	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Estate Planning	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Sale of Mutual Funds	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Segregated Funds	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
GICs Sales	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
RRIFs Sales	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
RRSPs Sales	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
RESPs Sales	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
Financial Planning (Fee only)	%		<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>
<b>TOTAL:</b>	<b>100%</b>						

**\*Describe**

b. If yes to Mutual funds, complete the following question: Does anyone in the brokerage/agency own or have any interest in a securities broker/dealer organization? Yes  No

c. Check each province where brokerage/agency is licensed:

- |                                       |                                               |                                                 |                                        |
|---------------------------------------|-----------------------------------------------|-------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alberta      | <input type="checkbox"/> British Columbia     | <input type="checkbox"/> Manitoba               | <input type="checkbox"/> New Brunswick |
| <input type="checkbox"/> Newfoundland | <input type="checkbox"/> Nunavut              | <input type="checkbox"/> North West Territories | <input type="checkbox"/> Nova Scotia   |
| <input type="checkbox"/> Ontario      | <input type="checkbox"/> Prince Edward Island | <input type="checkbox"/> Quebec                 | <input type="checkbox"/> Saskatchewan  |
| <input type="checkbox"/> Yukon        |                                               |                                                 |                                        |

7. Identify percentages of annual commission income during the last calendar year received as:

- a. Managing / Master General Agent (provide copy of MGA contract) ..... %
  - b. AGA/GA ..... %
  - c. Agency ..... %
- TOTAL: 100%**

8. a. List the top 3 **Insurance Carriers** by annual income, types of policies placed and annual income for each.

Complete Name of Insurance Carrier	Years Represented	Annual Income
		\$
		\$
		\$

b. List all **Insurance Carriers** with whom brokerage/agency contracts have been terminated in the last 5 years. (✓ if "None" )

Name of Insurance Carrier	Reason for Termination

9. Office Procedures for all locations:

- a. Are incoming documents date identified? .....  Yes  No  
**If no**, please provide details.
- b. Does the agency maintain a policy expiration list? .....  Yes  No  
**If no**, please provide details.
- c. Is there a procedure to maintain written documentation of all rejections of coverage? .....  Yes  No  
**If no**, please provide details.
- d. Is there a procedure to periodically review renewal risks for needed changes in coverage? .....  Yes  No  
**If no**, please provide details.
- e. Are all applications, policies and endorsements checked for accuracy? .....  Yes  No  
**If no**, please provide details.
- f. Is a verbal explanation of conditional receipts provided to your clients? .....  Yes  No  
**If no**, please provide details.
- g. Is there a procedure for documenting telephone conversations? .....  Yes  No  
**If no**, please provide details.
- h. What type of diary/suspense procedure does the agency use? (✓ if "None" )  Automated Procedure  
 Non-Automated Procedure
- i. Does applicant have a current Office Procedure Manual? .....  Yes  No
- j. Does applicant have a specific orientation program for new employees? .....  Yes  No
- k. Does the agency use an automated software system? .....  Yes  No
- l. What type of file system does the agency utilize?  Paper Files  Transactional  Imaging

10. After inquiry of each brokerage/agency personnel (listed under Q.5(a), are there any known circumstances or incidents, which may result in an errors and omissions claim being made against the brokerage/agency? .....  Yes  No

If **yes**, what is the total number of these potential claims not previously reported to Westport Insurance? \_\_\_\_\_

**Please provide a detailed description of each claim "or incident" including: description, date of loss, claim status (open or closed), demand amount and total loss incurred.** (details not required for claims or incidents previously reported to Westport Insurance Corporation's Claims Dept.)

11. Have any errors and omissions claims or incidents been made against the brokerage/agency or any of its past or present personnel or predecessor brokerage/agency, within the last 5 years? ...  Yes  No

If **yes**, what is the total number of these claims not previously reported to Westport Insurance? \_\_\_\_\_

**Please provide a detailed description of each claim "or incident" including: description, date of loss, claim status (open or closed), demand amount and total loss incurred.** (details not required for claims or incidents previously reported to Westport Insurance Corporation's Claims Dept.)

12. Has the brokerage/agency ever paid an uninsured loss out of brokerage/agency funds? .....  Yes  No

If **yes**, what is the total number of losses paid? \_\_\_\_\_

**Please provide a detailed description of each claim "or incident" including: description, date of loss, claim status (open or closed), demand amount and total loss incurred.** (details not required for claims or incidents previously reported to Westport Insurance Corporation's Claims Dept.)

13. Has any policy or application for Errors and Omissions insurance on behalf of the applicant or any of its past or present owners or personnel listed under Q.5 (a), or to the knowledge of the applicant, on behalf of its predecessors in business, ever been declined, canceled or renewal refused within the last 5 years? .....  Yes  No

If **yes**, please indicate: **Year:** \_\_\_\_\_

**Reason:**  Claim Experience  Carrier withdrew from market  Brokerage/agency Operations  Non-Payment

Other (Describe): \_\_\_\_\_

14. Has any past or present brokerage/agency personnel listed under Q5 (a) been the subject of complaints filed and/or disciplinary action by any insurance regulatory authority or convicted of a criminal activity? .....  Yes  No

If **yes**, provide a copy of the action pending or taken by the disciplinary body or judicial system.

15. Please provide the following on the **brokerage/agency's** prior 5 years of professional liability insurance: (✓ if "None" )

Name of Carrier	Expiration Date	Limit Each Claim	Deductible Each Claim	Premium	Policy Retro Date if "Full Prior Acts," ✓ box
	/ /	\$	\$	\$	/ / <input type="checkbox"/>
	/ /	\$	\$	\$	/ / <input type="checkbox"/>
	/ /	\$	\$	\$	/ / <input type="checkbox"/>
	/ /	\$	\$	\$	/ / <input type="checkbox"/>
	/ /	\$	\$	\$	/ / <input type="checkbox"/>

16. Requested Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

17. Requested Limit of Liability: Each Claim: \$ \_\_\_\_\_ Annual Aggregate \$ \_\_\_\_\_

18. Requested Deductible:  \$1,000  \$2,500  \$5,000

**PRIVACY NOTICE TO APPLICANT**

The undersigned applicant authorizes Westport Insurance Corporation (a) to collect his/her personal information in order to process and evaluate this application, to provide insurance if coverage is accepted, to obtain reinsurance for the policy, to investigate any claim made under the policy, which may require third parties to collect insured's personal information, and to serve other purposes as permitted by applicable law; (b) to disclose his/her personal information to its subsidiaries, affiliates, reinsurers and agents for these purposes, and (c) to use his/her personal information for these purposes. Furthermore, the undersigned authorizes any third party who receives undersigned's personal information from Westport Insurance Corporation to collect, use and further disclose the personal information for these purposes.

**NOTICE TO APPLICANT**

**Applicant hereby warrants and represents that the statements and answers to questions made above and attachments hereto are true and applicant has not omitted or misrepresented any information.**

I understand and accept that the policy applied for provides coverage on a "claims made and reported" basis for only those claims that are made against the insured while the policy is in force and that coverage ceases with the termination of the policy. All claims will be excluded that result from any acts, circumstances or situations known prior to the inception of coverage being applied for, that could reasonably be expected to result in a claim.

Applicant understands and agrees that the completion of this application does not bind WIC to issuance of any insurance policy. Further, the applicant understands and agrees that she or he is obligated to report any changes in information provided in this application that occur after the date of the application.

THE APPLICATION MUST BE SIGNED AND DATED BY THE APPLICANT.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
(Please Print)

*The applicant understands and agrees that she or he is obligated to report any changes in the information provided in this application which occur after the date of the application.*