



PRIVATE INVESTIGATOR PROFESSIONAL LIABILITY INSURANCE APPLICATION—LARGE RISKS

Return Applications to: **Fox Point Programs, Inc.**

250 Philadelphia Pike, 2nd Floor, Wilmington, DE 19809-3125

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NOTICE: THE POLICY FOR WHICH YOU ARE APPLYING IS WRITTEN ON A CLAIMS-MADE AND REPORTED BASIS. ONLY CLAIMS FIRST MADE AGAINST THE INSURED AND REPORTED TO THE COMPANY DURING THE POLICY PERIOD ARE COVERED SUBJECT TO THE POLICY PROVISIONS. THE LIMITS OF LIABILITY STATED IN THE POLICY ARE REDUCED, AND MAY BE EXHAUSTED, BY CLAIMS EXPENSES. CLAIMS EXPENSES ARE ALSO APPLIED AGAINST YOUR DEDUCTIBLE, IF APPLICABLE.

INSTRUCTIONS: Please type or print all answers clearly. Answer all questions completely, leaving no blanks. If there is insufficient space to complete an answer, please continue on a separate sheet indicating the question number. If any questions, or any part thereof, do not apply, print N/A in the space. Insert checks in Yes or No answer boxes, if any. This application must be completed, signed, and dated by an authorized officer of your firm. The Company will rely on all statements made in this application.

1 GENERAL INFORMATION

Applicant Name _____

dba Name _____

Mailing Address _____

City _____ State _____ Zip _____

Tel (_____) _____ Fax (_____) _____ E-mail _____

Do you operate from a residence? Yes No

Business Type: Individual Partnership Corporation Other (describe) _____

Years in Business _____ Date Business Established _____

Qualified Principal/Partner _____ Tax ID/SSN _____

State License Number _____ Licensed in State _____ **ATTACH COPY OF STATE LICENSE.**

Does the Applicant belong to any professional associations? Yes No *If "Yes", please list:* _____

2 FINANCIAL AND STAFFING INFORMATION

a. Indicate fiscal year end date: _____ / _____ (month/day) b. Provide gross annual receipts derived from all operations:

	Prior Year 2 _____	Current Year 2 _____	Est. Next Year 2 _____
Gross Annual Receipts \$	\$ _____	\$ _____	\$ _____

c. Annual Payroll for Employees (non clerical) \$ _____ d. Annual Amount Paid to Independent Contractors \$ _____ Number Used _____

EMPLOYED STAFF MEMBERS

TYPE	Full Time	Part Time	TYPE	Full Time	Part Time	TYPE	Full Time	Part Time
Owners/ Officers/Partners	_____	_____	Investigators	_____	_____	Adjusters	_____	_____
Background Checkers	_____	_____	Record Retriever	_____	_____	Clerical	_____	_____
Process Servers	_____	_____	Other Specify: _____	_____	_____	_____	_____	_____

e. Do you have a training program for employees? Yes No *If yes, describe:* _____

f. Do you require that all Independent Contractors maintain E&O Insurance? Yes No

g. *If "Yes", do you require that they submit evidence of coverage?* Yes No

3 OPERATIONS/TYPE OF WORK PERFORMED

a. Provide professional services by approximate percentage. *Must equal 100%.*

SERVICE PROVIDED	%	SERVICE PROVIDED	%	SERVICE PROVIDED	%
Activity Check	_____	Domestic.....	_____	Product Liability...	_____
Criminal	_____	Process Service	_____	Claims Adjuster....	_____
Polygraph	_____	Attorney Service.....	_____	Consulting	_____
AOE/COE.....	_____	Fidelity	_____	Property/Arson	_____
Civil	_____	Record Retrievers ..	_____	Computer Fraud...	_____
Locates/ Skip Tracing.....	_____	Background/ Credit Check.....	_____	Medical Malpractice	_____
Forensic Investigation.....	_____	Other (describe) _____	_____		

b. Indicate on whose behalf services are performed. *Must equal 100%.*

CLIENT	%
Insurance Carriers	_____
Private Parties	_____
Law Firms.....	_____
Public Entities.....	_____
Self Insureds	_____
Professional Sports Teams.....	_____
Other (describe)	_____

4 CLAIMS/LOSS HISTORY

a. Has the Applicant or any associated professional ever:

- i) Had a professional license or registration denied, suspended, revoked, non-renewed, or restricted? Yes No
 - ii) Been formally reprimanded by any court, administrative or regulatory agency? Yes No
 - iii) Been formally accused of violating any professional association's code of ethics? Yes No
 - vi) Been convicted of a felony? . . . Yes No *If the answer any question under 4a is "Yes", provide details on a separate sheet.*
- b. Has any Professional Liability claim(s), complaint or proceeding been made against the Applicant or any person or organization proposed for this insurance or any predecessor organization? Yes No
- c. Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, error, omission, circumstance, or situation that might provide grounds for any claim under the proposed insurance? Yes No
- d. Has the Applicant and/or any of its directors, officers, and/or employees, its predecessors, subsidiaries, affiliates, employees and/or any other person or organization proposed for this insurance been involved in or have knowledge of any pending or completed governmental regulatory, investigative, or administrative proceeding? Yes No
- If the answer to 4b, c, or d above is "Yes", complete the Supplemental Claims Questionnaire for each Claim, Notice, or Circumstance.*

5 PRIOR INSURANCE

a. Please provide the following information for any Errors & Omissions or Professional Liability Insurance the Applicant carried during the last three years:

COMPANY	LIMIT OF LIABILITY	DEDUCTIBLE	PREMIUM	POLICY PERIOD	RETRO DATE
	\$ /	\$	\$	/ /	/ /
	\$ /	\$	\$	/ /	/ /
	\$ /	\$	\$	/ /	/ /

b. Has any Errors & Omissions or Professional Liability Insurance issued to the Applicant ever been declined, cancelled, or non-renewed? Yes No *If the answer is "Yes", provide details on a separate sheet.*

NOTICE TO ALL APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

BY SIGNING THIS APPLICATION, THE APPLICANT REPRESENTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION, SUPPRESSED OR CONCEALED. THE UNDERSIGNED AGREES THAT IF AFTER THE DATE OF THIS APPLICATION AND PRIOR TO THE EFFECTIVE DATE OF ANY POLICY BASED ON THIS APPLICATION, ANY OCCURRENCE, EVENT, OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE UNDERSIGNED SHALL NOTIFY THE COMPANY OF SUCH OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE, OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

Printed Name & Title: _____

Applicant Signature: _____

Date (MM/DD/YY) ____ / ____ / ____

(Must be signed by an Officer of the Applicant)