

- o DEERFIELD INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
- o MARKEL INSURANCE COMPANY

**APPLICATION FOR SPECIFIED PROFESSIONS PROFESSIONAL LIABILITY INSURANCE AND
SERVICE AND TECHNICAL PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis or Claims Made and Reported Basis)**

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. Full name of Applicant: _____
2. Principal business premise address: _____
(Street) (County)

(City) (State) (Zip)
3. Address(es) of Branch Office(s): _____
4. Web Site Address(es): _____ 5. Phone Number: _____
6. Number of employees including principals: Full-time _____ Part-time _____ Seasonal _____ Total _____
7. Business is a: corporation partnership individual other _____
8. Date organized (MM/DD/YYYY): _____
9. Is the Applicant controlled by, owned by, or commonly owned, affiliated or associated with any other organization?
..... Yes No
If Yes, are any services provided to such organization(s)? Yes No
If Yes, to either of the above, provide details.
10. During the last year has the Applicant been involved in, or are they presently considering or contemplating:
(a) Any merger, consolidation or acquisition? Yes No
If Yes, provide a complete explanation detailing liabilities assumed and any professional liability coverage purchased
by any predecessor organization. _____
(b) A change in the nature of business operations? Yes No
If Yes, provide details. _____
11. During the last year has the name of the Applicant been changed Yes No
If Yes, provide details. _____

II. ADDITIONAL INFORMATION

1. If you are a new Applicant with this company, attach:
 - (a) A list of owners, partners and officers and percentage of ownership of each of the Applicant(s) named in Part I Item 1. above.
 - (b) Latest annual financial statements (annual report or income statement and balance sheet). (Omit if gross revenues are \$500,000 or less.)
 - (c) Professional qualifications (i.e. resume or c.v.) of each of the owners, partners, officers and key employees of the Applicant(s) named in Part I Item 1. above.
 - (d) Professional societies and organizations to which the Applicant and its owners, partners, officers and key employees belong(s).

- (e) Advertisements, brochures, and descriptive literature on the Applicant's business.
- (f) Sample contract for services between the Applicant and its clients.
- (g) A list of and description of affiliations with any organization owned by any owner, partner or officer of any Applicant.

2. If you are applying for renewal with this company, attach:

- (a) A list of owners, partners and officers and percentage of ownership of each in the Applicant(s) named in Part I. Item 1. above.
- (b) Latest annual financial statements (annual report or income statement and balance sheet). (Omit if gross revenues are \$500,000 or less.)
- (c) Any changes in any items provided last year pursuant to Items (c), (d), (e), (f) or (g) above.

III. PROFESSIONAL ACTIVITIES AND SPECIALTY

1. Describe all professional services performed for others and indicate the percentage of gross revenues derived from each activity.

Professional Services	Percent of Gross Revenues
_____	_____ %
_____	_____ %
_____	_____ %

- 2. (a) Estimated annual gross revenues for the coming year: \$ _____
- (b) Percentage of annual gross revenues for the coming year:
 - (i) Domestic: _____ %
 - (ii) Foreign: _____ %
- (c) Annual gross revenues for the last three years:
 - (i) last twelve months: Year: _____ \$ _____
 - (ii) 1st prior year: Year: _____ \$ _____
 - (iii) 2nd prior year: Year: _____ \$ _____

3. Describe Applicant's five largest jobs in the last three years:

Client Name	Professional Services	Gross Revenues
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Is the Applicant engaged in any business or profession other than as described in Item 1 above? Yes [] No []
 If Yes, explain. _____

5. Were more than 50% of the Applicant's gross revenues for any of the last three years derived from any one contract? Yes [] No []
 If Yes, specify client, professional services and duration of contract. _____

6. Does the Applicant utilize the services of independent contractors or sub-consultants? Yes [] No []
 If Yes, indicate percentage of billings and whether a certificate of professional liability insurance is required of each. _____

7. (a) Does the Applicant, any of its subsidiaries and/or affiliates build, service, repair, install, manufacture or fabricate anything? Yes [] No []
- (b) Does the Applicant, any of its subsidiaries and/or affiliates sell any product other than computer software? Yes [] No []
- If Yes, to either (a) or (b) describe. _____

IV. CLAIMS/HISTORY

1. During the last five years, have there been any professional liability claims against the Applicant, its predecessors, subsidiaries, affiliates, employees and/or against any other person or entity proposed for this insurance? Yes [] No []
- If Yes, attach complete details including description of allegations, status of claim, amounts demanded or paid, date of claim, and action taken to prevent the same type of claim in the future.
2. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which might afford grounds for any claim, such as would fall under the proposed insurance? [] Yes [] No []
- If Yes, provide details. _____
3. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for this insurance in the last five years? Yes [] No []
- If Yes, attach a copy of such insurer's notice.
4. Has the Applicant and/or any of its directors, officers and/or employees its predecessors, subsidiaries, affiliates, employees and/or any other person or entity proposed for this insurance been involved in or have knowledge of any pending or completed governmental regulatory, investigative or administrative proceedings? Yes [] No []
- If Yes, attach a copy of the outcome of such proceedings.

5. Previous Professional Liability Insurance:

Policy Period	Insurer	Indicate whether Claims Made or Occurrence policy	Limits of Liability	Deductible	Retro Date

6. Does the Applicant carry General Liability Insurance? Yes [] No []
- If yes, provide: Insurer: _____ Limits: _____
- Does coverage include Products/Completed Operations Hazards? Yes [] No []

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a claim or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or entity(ies) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there be knowledge of any such fact, circumstance or situation, any claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the extended reporting period option is exercised in accordance with the terms of the policy. The policy has specific provisions detailing claim reporting requirements.

Shand Morahan & Company, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which Shand Morahan & Company, Inc. receives notice is on file with Shand Morahan & Company, Inc. and is considered physically attached to and part of the of the policy if issued. Shand Morahan & Company, Inc. and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Shand Morahan & Company, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I/We warrant to the Company, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc. or the Company, Ten Parkway North, Deerfield, Illinois 60015.

Must be signed within 60 days of the proposed effective date.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SPECIALTY SUPPLEMENT REQUIRED

- Building/Home Inspector
- Collection Agency
- Crane Inspector
- Employee Placement
- Escrow Only
- Freight Forwarder / Customs Broker
- Insurance Related Services
- Media Related Service
- Mortgage Broker
- Premium Finance
- Real Estate Agent, Appraiser, Property Manager
- Testing Lab
- Third Party Administrator
- Title, Escrow & Closing
- Travel Related Services

ALTERNATE APPLICATION REQUIRED

- Association
- Computer Related Other Than Consulting
- Environmental
- Franchisor
- Trustees

Our Supplements and Applications are available at www.shand.com or by fax by calling (847) 572-6268.

Notice to Applicants: 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 the person to criminal and civil penalties.



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**DISCLOSURE NOTICE OF TERRORISM
INSURANCE COVERAGE AND ELECTION FORM**

RE:
Risk ID. No.:

You are hereby notified that under the Terrorism Risk Insurance Act of 2002 (the "Act"), effective November 26, 2002, that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, as defined in Section 102(1) of the Act ("Terrorism Coverage"): The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property; or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

You should know that Terrorism Coverage required to be offered by the Act for losses caused by certified acts of terrorism is partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States pays 90% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The premium charged for this Terrorism Coverage is provided below and does not include any charges for the portion of loss covered by the federal government under the Act.

SELECTION OR REJECTION OF TERRORISM INSURANCE COVERAGE

PLEASE ENTER "X" IN ONE OF THE BOXES BELOW AND SIGN AND DATE WHERE INDICATED BELOW.

Florida, Georgia and Oklahoma Applicants: Please be advised that in the event a policy is purchased, the policy premium will include a 1% surcharge for Terrorism Coverage unless you elect to decline Terrorism Coverage. You need to enter an "X" below if you wish to decline Terrorism Coverage.

	I hereby elect to purchase the Terrorism Coverage required to be offered under the Act. I understand that my policy premium will include a 3% surcharge for this coverage.
	I decline to purchase the Terrorism Coverage required to be offered under the Act. I understand that my policy will be endorsed to exclude the Terrorism Coverage required to be offered under the Act.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this Disclosure Notice does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance.

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**AVIATION SURVEY SUPPLEMENT
To Insurance Agents and Brokers Errors and Omissions Application**

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.
(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

Name of Applicant: _____

2. APPLICANT OPERATIONS

a. Aviation Premium Volume Written Annually: _____

b. Approximate % and number of accounts in:

	%	Accounts	% of Premium
Personal Business & Pleasure	_____	_____	_____
Industrial	_____	_____	_____
Commercial	_____	_____	_____
FBO	_____	_____	_____
Crop Dusting	_____	_____	_____
Charter	_____	_____	_____
Student instruction/rental	_____	_____	_____
Air carriers including charter	_____	_____	_____
Helicopter	_____	_____	_____
Life Flight	_____	_____	_____
Other Charter Specify	_____	_____	_____
_____	_____	_____	_____
Other (specify) _____	_____	_____	_____
TOTAL AGENCY:	_____	_____	_____

c. Type, volume and number of **non-aviation policies** related to aviation operations such as products liability for manufacturers and workers compensation.

Type	Premium	# of Accounts
_____	_____	_____
_____	_____	_____
_____	_____	_____

d. Premium volume and number of accounts that are float equipped:

Premium Volume	# of Accounts
_____	_____
_____	_____

e. Do you act as an adjustor or have any responsibility for adjusting claims? [] Yes [] No

f. (i) Licensed personnel who produce and underwrite aviation business in the agency: (Please attach experience resumes):

Name	Experience
_____	_____
_____	_____
_____	_____

(ii) Are any of the above licensed pilots? [] Yes [] No

g. Please describe agency procedure and attach forms used in binding aviation coverage and attach corresponding forms:

h. If the majority of your aviation business is written on a single entity or fleet, please describe that entity or fleet and its activities:

3. INSURANCE CARRIERS

a. Companies used for aviation coverages, premium volume and loss ratio:

Company	Premium Volume	Loss Ratio
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. (i) Do you represent any of the preceding companies as an agent? [] Yes [] No

(ii) Maximum limits you can bind on their behalf? Liability _____ Hull _____

(iii) Companies represented as agent: _____

c. What are the maximum limits you write? Liability _____ Hull _____

I understand information submitted herein becomes a part of my Insurance Agents & Brokers Errors and Omissions Application and is subject to the same representation and conditions.

Name of Applicant*

Title

Signature of Applicant

Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.

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AVIATION SURVEY SUPPLEMENT
To Insurance Agents and Brokers Errors and Omissions Application

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1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.
 (PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

Name of Applicant: _____

2. APPLICANT OPERATIONS

a. Aviation Premium Volume Written Annually: _____

b. Approximate % and number of accounts in:

	%	Accounts	% of Premium
--	---	----------	--------------

Personal Business & Pleasure	_____	_____	_____
Industrial	_____	_____	_____
Commercial	_____	_____	_____
FBO	_____	_____	_____
Crop Dusting	_____	_____	_____
Charter	_____	_____	_____
Student instruction/rental	_____	_____	_____
Air carriers including charter	_____	_____	_____
Helicopter	_____	_____	_____
Life Flight	_____	_____	_____
Other Charter Specify	_____	_____	_____

Other (specify) _____

TOTAL AGENCY: _____

c. Type, volume and number of **non-aviation policies** related to aviation operations such as products liability for manufacturers and workers compensation.

Type	Premium	# of Accounts
_____	_____	_____
_____	_____	_____
_____	_____	_____

d. Premium volume and number of accounts that are float equipped:

Premium Volume	# of Accounts
_____	_____
_____	_____

e. Do you act as an adjustor or have any responsibility for adjusting claims? [] Yes [] No

f. (i) Licensed personnel who produce (and underwrite aviation business in the agency: (Please attach experience resumes):

Name	Experience
_____	_____
_____	_____
_____	_____

(ii) Are any of the above licensed pilots? [] Yes [] No

g. Please describe agency procedure and attach forms used in **binding** aviation coverage and attach corresponding forms:

h. If the majority of your aviation business is written on a single entity or fleet, please describe that entity or fleet and its activities:

3. INSURANCE CARRIERS

a. Companies used for aviation coverages, premium volume and loss ratio:

Company	Premium Volume	Loss Ratio
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. (i) Do you represent any of the preceding companies as an agent? [] Yes [] No

(ii) Maximum limits you can bind on their behalf? Liability _____ Hull _____

(iii) Companies represented as agent: _____

c. What are the maximum limits you write? Liability _____ Hull _____

I understand information submitted herein becomes a part of my Insurance Agents & Brokers Errors and Omissions Application and is subject to the same representation and conditions.

Name of Applicant*

Title

Signature of Applicant

Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.

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SUPPLEMENT FOR INSURANCE RELATED SERVICES

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

2. Line(s) of Business on which the Applicant provides their services:

		Percentage
(a) Life	[] Yes [] No	_____ %
(b) Accident /Health	[] Yes [] No	_____ %
(c) Pension	[] Yes [] No	_____ %
(d) Other Benefits: (specify) _____	[] Yes [] No	_____ %
(e) Personal Property Home or Auto	[] Yes [] No	_____ %
(f) Personal Liability Home or Auto	[] Yes [] No	_____ %
(g) Commercial Property	[] Yes [] No	_____ %
(h) Workers' Compensation	[] Yes [] No	_____ %
(i) General Liability	[] Yes [] No	_____ %
(j) Other (specify) _____		_____ %
TOTAL		100%

3. Provide the percentage of the Applicant's clients in the following categories:

		Percentage
(a) Insurers		_____ %
(b) Insureds		_____ %
(c) Self Insureds		_____ %
(d) Other (specify) _____		_____ %
TOTAL		100%

4. List the Insurers and/or Risk Bearing Entities for which the Applicant provides professional services to account for 85% of the Applicant's gross revenues.

Insurer or Risk Bearing Entity	Best's Rating (If applicable)
_____	_____
_____	_____
_____	_____
_____	_____

5. Does the Applicant adjust claims? [] Yes [] No
If Yes, answer the following.

- (a) Does the Applicant have authority to deny coverage for claims? [] Yes [] No
- (b) Largest Single Loss Adjusted in the past 36 months in dollar amount of settlement: \$ _____
- (c) Average Size of Loss Adjusted in the past 36 months in dollar amount of settlement: \$ _____

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

Name of Applicant

Title

Signature of Applicant

Date

- o DEERFIELD INSURANCE COMPANY
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OLD NATIONAL INSURANCE

205-221-5466 PHONE

205-221-5570 FAX

SUPPLEMENT FOR CRANE INSPECTION SERVICES

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

2. Indicate the percentage of total services provided in each of the following areas:

			Percentage
(a) Shipyard Crane and Rigging Inspection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(b) Non-Shipyard Crane and Rigging Inspection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(c) Welding Inspection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(d) Crane and Equipment Service and/or Repair*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(e) Construction Site Inspection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(f) Non-Destructive Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(g) Operator Training	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(h) Other (specify) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
TOTAL			100%

3. How many inspections does the Applicant perform annually? _____

4. Provide details of the types of clients for which services are provided:

			Percentage
(a) Utility Companies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(b) Manufacturers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(c) General Construction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(d) Shipyards/Loading Docks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(e) Mining Operations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
(f) Other (specify) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____ %
TOTAL			100%

5. Do you subcontract inspection work to others? Yes No If yes, what percentage of revenue? _____% Do you require evidence of appropriate license or accreditation? Yes No Do you require evidence of Professional Liability (E&O) insurance with limits equal to those being applied for? Yes No

6. Do you subcontract repair, servicing, "wrench turning," installation, fabrication or construction of any kind whatsoever? Yes No

7. Indicate if Applicant's training and accreditation includes:

(a) State OSHA Accreditation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) Federal OSHA Accreditation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c) Member of Crane Certification Association	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(d) Member Association of Crane Rigging Professionals	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. Please attach the following items to this submission.

- (a) Copies of Professional Licenses and/or Accreditations
- (b) Resumes of All Active Owners and Key Employees
- (c) Load Test Procedures Document
- (d) Client Service Agreement or Disclaimer Wording Used
- (e) Written Contracts Used
- (f) Certificate of General Liability Insurance In Force

9. Is General Liability Coverage desired? Yes No NOTE: General Liability is not available if the applicant performs or subcontracts any repair, servicing, "wrench turning," installation, fabrication or construction of any kind whatsoever.

*NOTE: No coverage is afforded for repair, servicing, "wrench turning," installation, fabrication or construction of any kind whatsoever.

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

Name of Applicant

Title

Signature of Applicant

Date