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?	❑	❑	________
Mechanical, electrical, chemical, civil or architectural design or engineering?	❑	❑	________
Fund transfers or financial transactions?	❑	❑	________
Aircraft, air-ground equipment, military defense and/or weaponry of any kind?	❑	❑	________
Medical, dental or healthcare diagnosis, monitoring or treatment?	❑	❑	________
Pharmaceutical formulation, production or prescriptions?	❑	❑	________
911 or other emergency response and/or dispatch?	❑	❑	________
Energy, power plant, utility or pollution monitoring, supply or distribution?	❑	❑	________
Computer security services intended to protect financial assets or privileged government information not intended for public usage/ consumption?	❑	❑	________

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

Capstone
UNDERWRITERS INC.

CONSULTANTS AND SPECIFIED PROFESSIONS PROFFESSIONAL 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 ❑ **Yes** ❑ **No** Central Station ❑ **Yes** ❑ **No**

    Sprinklers ❑ **Yes** ❑ **No** Central Station ❑ **Yes** ❑ **No**

    Fire Alarm ❑ **Yes** ❑ **No** Central Station ❑ **Yes** ❑ **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:____ Date: ______________________

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

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.