



# Zain Jeewanjee Insurance Agency

a member of U.S. Risk Insurance Group, Inc

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Place cursor on first line to begin typing, when finished print and fax to your underwriter

ADJUSTING, APPRAISAL, CLAIMS ADMINISTRATION, INVESTIGATOR,  
ATTORNEY SERVICES/PROCESS SERVICE, AUDIT & INSPECTIONS

INFORMATION HEREIN IS CONSIDERED CONFIDENTIAL

1. Applicant's Name (include all firm names, trading names or DBA's under which you operate)

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

- Individual
- Partnership
- Corporation

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Tele: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Month/Year firm established under current ownership: \_\_\_\_\_

Internet Address: \_\_\_\_\_

List any Branch Offices: \_\_\_\_\_ Professional Organizations to which firm belongs: \_\_\_\_\_

Name of Firm Principals	Title	Years of Experience	Professional Designations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. DESCRIPTION OF OPERATIONS (Please indicate percent of revenues. If you are involved in several of the areas listed below, the total for ALL areas must equal 100%.)

### ADJUSTER

- Property \_\_\_\_\_%
- Casualty \_\_\_\_\_%
- Workers Comp. \_\_\_\_\_%
- Liquor Liability \_\_\_\_\_%
- Environmental \_\_\_\_\_%
- Marine (Post-Occ) \_\_\_\_\_%
- Professional Liability \_\_\_\_\_%
- Aviation \_\_\_\_\_%
- Catastrophe \_\_\_\_\_%
- Public Adjusting \_\_\_\_\_%
- Other, please explain \_\_\_\_\_%

### APPRAISER

- Insurance-Related Appraisal \_\_\_\_\_%
- Non-Insurance Appraisal \_\_\_\_\_%
- Business Valuations \_\_\_\_\_%
- Real Estate Appraisal \_\_\_\_\_%
- Other, please explain \_\_\_\_\_%

### CLAIMS ADMINISTRATION

- Workers Compensation \_\_\_\_\_%
- Property/Casualty \_\_\_\_\_%
- Life/Health/Disability (TPA's) \_\_\_\_\_%
- Self-insureds \_\_\_\_\_%
- Loss Control Activities \_\_\_\_\_%
- Other, please explain \_\_\_\_\_%

### AUDIT & INSPECTION

- Safety Engineer \_\_\_\_\_%
- Loss Control \_\_\_\_\_%
- Marine Condition/Value \_\_\_\_\_%
- Underground Storage Tanks \_\_\_\_\_%
- Insurance Premium Audits \_\_\_\_\_%
- Other, please explain \_\_\_\_\_%

### ATTORNEY SERVICE

- Process Service \_\_\_\_\_%
- Paralegal Services \_\_\_\_\_%
- Photocopying (Legal or Med.) \_\_\_\_\_%
- Legal Support \_\_\_\_\_%
- Polygraph Examination \_\_\_\_\_%
- Other, please explain \_\_\_\_\_%

### INVESTIGATOR

- Investigations for:
- Insurance Cos./Court System \_\_\_\_\_%
- Private Corps./Individuals \_\_\_\_\_%
- Financial Institutions \_\_\_\_\_%
- Repossessions \_\_\_\_\_%
- Background/Credit \_\_\_\_\_%
- Other, please explain \_\_\_\_\_%

### FORENSIC/EXPERT WITNESS

- Indicate Specialty: \_\_\_\_\_%
- Expert Testimony \_\_\_\_\_%
- Litigation Support and Consultation \_\_\_\_\_%
- Accident Reconstruction \_\_\_\_\_%
- Pre-Market Testing \_\_\_\_\_%
- Post-Occurrence Product Testing \_\_\_\_\_%
- Design Work \_\_\_\_\_%
- Other, please explain \_\_\_\_\_%

- Do you engage in security-related services, such as alarm installation, patrol services, security guard or escort services?  Yes  No
- Average Caseload per individual per month \_\_\_\_\_
- Do you act as an agent or broker in the placement of insurance coverage?  Yes  No
- Will you issue reservation of rights or declination of coverage letters?  Yes  No
- If Yes, is this authority defined in writing from the carrier?  Yes  No
- Do you have a fee collection process which minimizes the need to file suit to collect your fees?  Yes  No

Please describe your professional activities:

### 3. GENERAL INFORMATION

A. After diligent inquiry, has the Applicant or any of its predecessors in business, subsidiaries, affiliates, past or present partners, owners, salespersons, employees, or independent contractors:

1. Been investigated or are currently under investigation and/or cited by any regulatory agency, professional review board, or any similar body for violations arising out of your activities?  Yes  No If yes, please attach an explanation.
2. Been convicted of a felony?  Yes  No If yes, name the court and describe the nature of the conviction,
3. Had a professional license expired, been suspended or revoked?  Yes  No If yes, identify the state, agency, date and reason for the suspension or revocation.
4. Had an application for a professional license been denied?  Yes  No If yes, please attach an explanation.
5. Had any claims or lawsuits during the past 5 years?  Yes  No If yes, please complete the attached Supplement Claim Form.
6. Learned of any incidents, circumstances, acts, errors, or omissions that could result in a claim being made against them?  Yes  No If yes, please complete the attached Supplement Claim Form.

B. Gross Revenues (all sums billed for services rendered)

Actual for past fiscal year: \$ \_\_\_\_\_

Estimate for coming fiscal year: \$ \_\_\_\_\_

C. Number of Individuals employed by Firm

Professional Staff:	_____ Full Time	_____ Part Time
Independent Contractors:	_____ Full Time	_____ Part Time
Clerical:	_____ Full Time	_____ Part Time
Other (Please Specify) _____	_____ Full Time	_____ Part Time

What percentage of your gross revenue is generated by independent contractors? \_\_\_\_\_%

What percentage of your Professional Staff have worked for you for over two years? \_\_\_\_\_%

D. List your top three clients, type of services performed and percentages of annual gross revenues. (This information is needed for underwriting purposes only and is considered confidential between the Applicant and the Company.)

Client	Description of Services	Percentage of Revenue
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

E. Do you use any promotional material?  Yes  No If yes, please attach a copy.

F. Do you require a written contractor agreement for services you provide to your clients?  Yes  No  
If yes, please attach a sample.

4. PREVIOUS COVERAGE INFORMATION: List each Carrier for the past 3 years. If none, state none.

A. Carrier	Policy Period	Limits	Deductible	Premium
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. Does your current coverage include General Liability?  Yes  No  
Is your current coverage written on a Claims-Made Form?  Yes  No If yes, what is your retroactive date? \_\_\_\_\_

C. Has any application for similar insurance made on behalf of the firm, its present partners, or any of its predecessors in business been declined, or has any such insurance been canceled, rescinded or refused renewal?  Yes  No If yes, please attach a brief explanation.

PLEASE NOTE: If you currently have Errors & Omissions coverage in place on a claims-made form, you may want to purchase prior acts coverage. For a quote, please include a copy of your current declarations page evidencing continuous claims-made coverage back to the retroactive date you desire.

## 5. QUOTE REQUEST

Please indicate which limit and deductible you would like quoted.

### LIMITS\*

- \$100,000/\$300,000
- \$200,000/\$600,000
- \$300,000/\$600,000
- \$500,000/\$1,000,000
- \$1,000,000/\$1,000,000
- \$2,000,000/\$2,000,000
- Other

### DEDUCTIBLE

- \$0
- \$2,500
- \$5,000
- \$10,000
- Other

\*Limits of Liability to \$10 million are available

Would you like your quote to include general liability?  Yes  No

### NOTICE TO APPLICANT - PLEASE READ CAREFULLY

#### WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 (NY: SUBSTANTIAL) CIVIL PENALTIES. IN MAINE AND VIRGINIA, INSURANCE BENEFITS MAY ALSO BE DENIED

#### SIGNATURE AND AGREEMENTS

THE APPLICANT AND FIRM ACCEPT NOTICE THAT ANY POLICY ISSUED WILL APPLY ON A "CLAIMS-MADE" BASIS.

The undersigned is authorized by and acting on behalf of the Applicant and represents that all statements and particulars herein are true, complete and accurate and that there has been no suppression or misstatement of fact and agrees that this application shall be the basis of coverage and become a part of any Policy issued by the Company.

THE APPLICANT ACCEPTS NOTICE THAT HE/SHE IS REQUIRED TO PROVIDE WRITTEN NOTIFICATION TO THE COMPANY OF ANY CHANGES IN THE RESPONSES GIVEN TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE.

Except to such an extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED and reported to the company while the policy is in force and which arise from services performed on or after the Retroactive Date of the policy.

NOTE: THE APPLICATION MUST BE SIGNED BY AN ACTIVE OWNER, PARTNER, OR EXECUTIVE OFFICER.

\_\_\_\_\_  
Signature of Applicant and Title

\_\_\_\_\_  
Date

SIGNING THIS FORM OR SENDING PREMIUM WITH THIS APPLICATION NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.

#### INDIVIDUAL CLAIM DATA REPORT

APPLICANT'S INSTRUCTIONS:

1. This form is to be completed by Applicant regarding any claim or suit during the past five (5) years or any facts, circumstances, acts, errors, or omissions of which applicant is aware which may give rise to a claim. COMPLETE ONE FORM FOR EACH SUCH CLAIM OR CIRCUMSTANCE.
2. If additional "Individual Claim Data Reports" are required, please photocopy blank report.
3. If space is insufficient to answer any question fully, attach a separate sheet.
4. Answer all questions completely.

(PLEASE TYPE OR PRINT)

1. Full name of Applicant:

\_\_\_\_\_

2. Full name of individual(s) involved or named in the claim:

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

3 Full name of Claimant:

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

4. Indicate whether: Claim/suit: \_\_\_\_\_ Incident: \_\_\_\_\_

5. Date of alleged error: \_\_\_\_\_ Date of claim: \_\_\_\_\_

6. Additional defendant (if any):

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

7. IF CLOSED:

Total Loss Paid including Deductible: \$ \_\_\_\_\_

Legal Expenses Paid: \$ \_\_\_\_\_

8. IF PENDING:

Claimant's settlement demand \$ \_\_\_\_\_ Loss reserves \$ \_\_\_\_\_

Defendant's offer of settlement \$ \_\_\_\_\_ Loss paid to date \$ \_\_\_\_\_

Expense reserves \$ \_\_\_\_\_ Expenses paid to date \$ \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Is claim in suit: Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Amount asked in summons? \$ \_\_\_\_\_

9. Name of Insurer (if any) \_\_\_\_\_

10. Description of claim: (Provide enough information to allow evaluation and use back of this page or separate exhibit if additional space is required.)

A. Alleged act, error or omission upon which claimant bases claim:

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

B. Description of the type and extent or injury or damage allegedly sustained:

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

I understand information submitted herein becomes a part of the proposal and is subject to the same warranty and conditions.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_