



# PROFESSIONAL / SPECIALTY INSURANCE APPLICATION

(FOR USE IN MANAGEMENT, EXECUTIVE & PROFESSIONAL LINES - APPLICANT SECTION)

DATE (MM/DD/YYYY)

AGENCY <b>TMK RISK MANAGEMENT INC</b> <b>DBA KALLMAN INSURANCE</b> <b>PO BOX 266736</b> <b>WESTON , FL 33326</b>		<b>CARRIER</b> UNDERWRITER UNDERWRITER OFFICE POLICIES OR PROGRAM REQUESTED		NAIC CODE
AGENCY'S STATE LICENSE #: (Required in Nebraska) CONTACT NAME:		POLICY NUMBER		
PHONE (A/C, No, Ext): <b>954-389-5897</b>		FAX (A/C, No): <b>954-389-6661</b>		
E-MAIL ADDRESS: <b>AKALLMAN@TMKRISK.COM</b>				
CODE:		SUBCODE:		
AGENCY CUSTOMER ID:				

INDICATE SECTIONS ATTACHED		PROFESSIONAL LIABILITY			BUSINESS TYPE		
<input type="checkbox"/>	CRIME	<input type="checkbox"/>	ACCOUNTANTS PROFESSIONAL	<input type="checkbox"/>	INTERNET LIABILITY	<input type="checkbox"/>	PUBLIC
<input type="checkbox"/>	D&O (Directors & Officers)	<input type="checkbox"/>	ARCHITECTS PROFESSIONAL	<input type="checkbox"/>	TECHNOLOGY	<input type="checkbox"/>	PRIVATE
<input type="checkbox"/>	E&O (Errors & Omissions)	<input type="checkbox"/>	INSURANCE AGENTS	<input type="checkbox"/>	WORKPLACE VIOLENCE	<input type="checkbox"/>	NOT FOR PROFIT
<input type="checkbox"/>	EPLI (Employment Practices Liability)	<input type="checkbox"/>	LAWYERS PROFESSIONAL	<input type="checkbox"/>	MISC PROFESSIONAL LIABILITY:	<input type="checkbox"/>	HEALTH CARE
<input type="checkbox"/>	FIDUCIARY	<input type="checkbox"/>	MEDIA PROFESSIONAL			<input type="checkbox"/>	FINANCIAL INSTITUTION
<input type="checkbox"/>	KIDNAP / RANSOM	<input type="checkbox"/>	MEDICAL MALPRACTICE				

<b>STATUS OF TRANSACTION</b>				<b>POLICY INFORMATION</b>			
<input type="checkbox"/>	QUOTE	<input type="checkbox"/>	ISSUE POLICY	<input type="checkbox"/>	RENEWAL	<input type="checkbox"/>	NEW
BOUND (Give Date and/or Attach Copy): DATE: _____ TIME: _____ AM/PM				ENTER THIS INFORMATION WHEN COMMON DATES AND TERMS APPLY TO SEVERAL LINES, OR FOR MONOLINE POLICIES.			
PROPOSED EFF DATE		PROPOSED EXP DATE		BILLING PLAN		PAYMENT PLAN	
				<input type="checkbox"/> DIRECT BILL <input type="checkbox"/> AGENCY BILL			

<b>APPLICANT / FIRM INFORMATION (As Applicable)</b>														
NAME (First Named Insured and Other Named Insureds)		MAILING ADDRESS INCL ZIP+4 (of First Named Insured)												
FEIN # (of First Named Insured): SOC-SEC # (if no FEIN) (of First Named Insured):		APPLICANT'S TITLE:												
PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		NAICS CODE:	SIC CODE:											
SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		CR BUREAU NAME:												
FAX (A/C, No):		ID NUMBER:												
WEBSITE ADDRESS(ES):		PRIMARY E-MAIL ADDRESS:												
SECONDARY E-MAIL ADDRESS:		SECONDARY E-MAIL ADDRESS:												
<input type="checkbox"/>	INDIVIDUAL	<input type="checkbox"/>	CORPORATION	<input type="checkbox"/>	SUBCHAPTER "S" CORPORATION	<input type="checkbox"/>	LLC	NO. OF MEMBERS AND MANAGERS: _____	<input type="checkbox"/>	OTHER:	OPERATIONS <input type="checkbox"/> U.S. <input type="checkbox"/> NON U.S.		STATE OF INCORP	DATE BUSINESS STARTED
<input type="checkbox"/>	PARTNERSHIP	<input type="checkbox"/>	JOINT VENTURE	<input type="checkbox"/>	PC	<input type="checkbox"/>	GP / LLP							
<b>TOTAL EMPLOYEES</b> FULL TIME: _____ PART TIME: _____			<b>TOTAL PAYROLL</b> \$ _____		<b>TOTAL REVENUES</b> \$ _____			<b>TOTAL ASSETS</b> \$ _____			<b>TOTAL LIABILITIES</b> \$ _____			

<b>CONTACT INFORMATION (Attach additional sheets if more space is required)</b>			
PRIMARY CONTACT NAME:		CONTACT TYPE:	
PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
PRIMARY E-MAIL ADDRESS:		SECONDARY E-MAIL ADDRESS:	

<b>NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS</b>

**GENERAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES

Y / N

1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ?

PARENT COMPANY	RELATIONSHIP	% OWNERSHIP BY PARENT

1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES?

NAME OF SUBSIDIARY	RELATIONSHIP	% OWNERSHIP BY APPLICANT

2. ANY OTHER INSURANCE WITH THIS COMPANY OR BEING SUBMITTED?

3. HAS ANY POLICY OR COVERAGE BEING APPLIED FOR BEEN DECLINED, CANCELLED OR NON-RENEWED? (Not applicable in MO)

4. ANY BANKRUPTCIES, TAX OR CREDIT LIENS AGAINST THE APPLICANT IN THE PAST FIVE (5) YEARS?

5. HAS BUSINESS BEEN PLACED IN A TRUST?  
IF YES, NAME OF TRUST:

6. ARE THERE ANY PREDECESSOR FIRMS?

**REMARKS**

**PRIOR CARRIER INFORMATION (List Current Primary Policy First)**

LINE	CATEGORY																
L I A B & O L I T Y	CARRIER																
	POLICY NUMBER																
	POLICY TYPE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE				
	EFF-EXP DATE																
	RETRO DATE																
	CONTINUITY DATE																
	LIMIT PER CLAIM																
	RETENTION																
	DEDUCTIBLE																
	ADDITIONAL LAYERS	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO				
TOTAL PREMIUM																	
E P L I	CARRIER																
	POLICY NUMBER																
	POLICY TYPE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE				
	EFF-EXP DATE																
	RETRO DATE																
	CONTINUITY DATE																
	LIMIT PER CLAIM	OCCURRENCE	AGGREGATE	OCCURRENCE	AGGREGATE	OCCURRENCE	AGGREGATE	OCCURRENCE	AGGREGATE	OCCURRENCE	AGGREGATE	OCCURRENCE	AGGREGATE				
	RETENTION																
	DEDUCTIBLE																
	TOTAL PREMIUM																
C R I M E	CARRIER																
	POLICY NUMBER																
	POLICY TYPE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE				
	EFF-EXP DATE																
	LIMIT																
	DEDUCTIBLE																
	TOTAL PREMIUM																
O T H E R	CARRIER																
	POLICY NUMBER																
	POLICY TYPE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE	CLAIMS MADE	OCCURRENCE				
	EFF-EXP DATE																
	LIMIT																
	DEDUCTIBLE																
	TOTAL PREMIUM																
<b>ATTACHMENTS</b>																	
FINANCIALS																	
CARRIER LOSS RUNS																	
CARRIER SUPPLEMENT(S)																	

**LOSS HISTORY (Attach additional sheets if more space is required)**

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY)

CHK HERE IF NONE

SEE ATTACHED LOSS SUMMARY

**TOTAL LOSSES:**

DATE OF OCCURRENCE	LINE OF BUSINESS	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM / NOTICE	AMOUNT PAID	AMOUNT RESERVED	CLAIM STATUS	
						OPEN	CLSD

**REMARKS**

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**SIGNATURE**

COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT. (Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US. (Not applicable in MN)

MINNESOTA RESIDENTS SHOULD SUBMIT ACORD 38 MN TO AUTHORIZE RELEASE OF PERSONAL INFORMATION.

IMPORTANT: CREDIT SCORING CANNOT BE USED IN OREGON FOR RENEWALS UNLESS REQUESTED BY THE INSURED.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN KANSAS, ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

I REPRESENT THAT I AM AN AUTHORIZED EMPLOYEE OF THE PROSPECTIVE NAMED INSURED. I ALSO REPRESENT THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS HEREIN WHICH ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT SIGNING THIS APPLICATION SHALL NOT CONSTITUTE A BINDER OR OBLIGATE THE COMPANY TO COMPLETE THIS INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS UPON WHICH A POLICY MAY BE ISSUED.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in FL and NE)
APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER