

# Application for Insurance

Professional Liability Insurance for Financial Agencies and Firms

THIS IS AN APPLICATION FOR A "CLAIMS MADE" POLICY

(Words and expressions, other than in the headings, printed in bold are defined in the policy form.)

Notice: If issued, the policy will be on a Claims made basis, and will be issued in reliance of the completeness and accuracy of the disclosures and statements in this application. The limits of liability and any deductible will apply to any Defence Costs payable under the policy.

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## 1. General Information

Name of Applicant (Company/Entity to be insured) \_\_\_\_\_

Address of principal office of the Applicant: \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax No. \_\_\_\_\_

Email Address \_\_\_\_\_

Contact Name \_\_\_\_\_

Contact's Email Address \_\_\_\_\_

Year Established \_\_\_\_\_ Province of Incorporation: \_\_\_\_\_

Type of Company  Corporation  Partnership  Other

### Branch Office(s)

Number of Branches/Offices \_\_\_\_\_ If more than two, click link to enter additional offices.

Note: This includes both official branch offices, and, if owners/employees work out of different home offices.

1. Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

2. Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

3. Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

### Subsidiary(ies)

Number of Subsidiaries \_\_\_\_\_ If more than two, click link to enter more.

Do you want coverage for Subsidiaries:  Yes  No

1. Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

2. Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Please provide a list of all Predecessor Firms to the Applicant for whom coverage is required under the policy, if issued.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## 2. Advisor Information

For all company(ies) stated above please provide the following:

(a) Number of individuals involved in the rendering of Professional Services:

(i) licensed employees: \_\_\_\_\_ (ii) unlicensed employees: \_\_\_\_\_

(iii) independent contracted advisors: \_\_\_\_\_ (must carry own E&O insurance)

note: for underwriting purposes contracted advisors will be counted as employees of the company

(b) Of all licensed staff how many have their Individual E&O with the Advocis Insurance? \_\_\_\_\_

(c) List of all partners, directors and officers involved in the rendering of Professional Services. (Attach Curriculum Vitae)

1. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

2. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

3. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

4. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

5. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

6. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

7. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

8. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

9. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

10. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

11. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

12. Name \_\_\_\_\_ Title \_\_\_\_\_

Licensed  Life  MFDA  IIROC  Personal E&O with Advocis Insurance?

If additional space is required click [here](#) or attach separate sheet to application.

### 3. Company Information

Please attach a copy of the Applicant's latest annual report, including audited financial statements with all notes and schedules, and any other relevant financial materials. (Not required if at last financial year end or current fiscal year end revenues are less than \$1,000,000.)

Please provide a general description of the business of the Applicant for which coverage is requested:

<input type="checkbox"/> Life Insurance Agency	<input type="checkbox"/> MGA/AGA Activities	<input type="checkbox"/> Financial Planning
Coverage Requested	Coverage Requested	Coverage Requested
<input type="checkbox"/> Mutual Fund Dealer/Agency	<input type="checkbox"/> Travel Insurance Sales	<input type="checkbox"/> Investment Counselling/ Portfolio Management*
Coverage Requested	Coverage Requested	Coverage Requested
<input type="checkbox"/> Other Activities - Please list	<input type="checkbox"/> Exempt Market Products Dealer*	<input type="checkbox"/> IIROC Licensed Agency*

\*Coverage not available under this program. Please contact ABS directly for alternative coverage options.

Other activities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If applying for coverage as a Licensed Life Agency, please indicate the top 10 Insurance Carriers with which you are contracted to sell or distribute on behalf of and the percentage of company revenue derived from each carrier. List Carrier Names.

1	%	6	%
2	%	7	%
3	%	8	%
4	%	9	%
5	%	10	%

If applying for coverage as an MGA/AGA, please indicate the top 10 Insurance Carriers with which you are contracted to sell or distribute on behalf of and the percentage of company revenue derived from each carrier.

1	%	6	%
2	%	7	%
3	%	8	%
4	%	9	%
5	%	10	%

If applying for coverage as a Mutual Fund Dealer (or for mutual fund activities), please indicate the top 10 Fund Management Companies with which you are contracted to sell or distribute on behalf of and the percentage of company revenue derived from each Fund Manager.

1	%	6	%
2	%	7	%
3	%	8	%
4	%	9	%
5	%	10	%

#### 4. Nature of Business

For all applicant(s) stated in Question 1:

(a) Please describe the nature of operations and Professional Services rendered by the Applicant for which coverage is required relative thereto:

(Please attach copy of Corporate Brochure, if available.)

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Last completed Fiscal Year is from: \_\_\_\_\_ yyyy/mm \_\_\_\_\_ to: \_\_\_\_\_ yyyy/mm \_\_\_\_\_

(b) Gross Revenue for the last completed Fiscal Year: \_\_\_\_\_

(c) Estimated Gross Revenue for the current Fiscal Year: \_\_\_\_\_

(d) Does the applicant provide services or perform activities outside Canada or for clients who are domiciled outside of Canada?  Yes  No

If yes, please provide full details:

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Service	Current Year	Prior Year	Activity Performed	Revenue	Coverage Desired
	(Type 0.30 for 30%)				
Life Insurance, accident & sickness, disability & critical illness			<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No
GICs, annuities & segregated funds*			<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No
Group Benefits, including Retirement Planning			<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sale of Mutual Funds*			<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No
Securities (bonds, preferred shares, equities etc.)* +			<input type="checkbox"/> Yes		N/A
Hedge Funds, Flow Through Shares, PPN's & Other Exempt Market Products +			<input type="checkbox"/> Yes		N/A
Fee For Service Financial Planning (Licensed Activities)			<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No
Travel Insurance			<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Includes RRSP, RESP and RRIF and any other government registered savings or investment plans.

+ Coverage not provided for Securities, Hedge Funds, Flow Throw Shares, PPNs and other EMPs.

(e) If Yes to "other" in the previous table, please describe the types of financial services and sales you provide service for:

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(f) Please check each province where the agency/firm is licensed:

Life/A&S Agency

- |                                       |   |  |  |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Alberta      | <input type="checkbox"/> British Columbia     | <input type="checkbox"/> Manitoba              | <input type="checkbox"/> New Brunswick |
| <input type="checkbox"/> Newfoundland | <input type="checkbox"/> Nunavut              | <input type="checkbox"/> Northwest Territories | <input type="checkbox"/> Nova Scotia   |
| <input type="checkbox"/> Ontario      | <input type="checkbox"/> Prince Edward Island | <input type="checkbox"/> Quebec                | <input type="checkbox"/> Saskatchewan  |
| <input type="checkbox"/> Yukon        |   |  |  |

Mutual Fund Agency

- |                                       |   |  |  |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Alberta      | <input type="checkbox"/> British Columbia     | <input type="checkbox"/> Manitoba              | <input type="checkbox"/> New Brunswick |
| <input type="checkbox"/> Newfoundland | <input type="checkbox"/> Nunavut              | <input type="checkbox"/> Northwest Territories | <input type="checkbox"/> Nova Scotia   |
| <input type="checkbox"/> Ontario      | <input type="checkbox"/> Prince Edward Island | <input type="checkbox"/> Quebec                | <input type="checkbox"/> Saskatchewan  |
| <input type="checkbox"/> Yukon        |   |  |  |

(g) To whom does the Applicant render Professional Services?

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(h) Does any one client represent more than 25% of the Applicant's annual revenue?  Yes  No

If yes, please provide details.

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(i) What organizations regulate the practice of your profession/business activities on a mandatory basis?

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(j) What other professional associations does the Applicant or it's owners/employees belong to?

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(k) Has or does the Applicant sub-contract the rendering of Professional Services to sub-contractors (other than sub-agents)?  Yes  No

If yes, what percentage? \_\_\_\_\_

If yes, please advise what Professional Services have or may be sub-contracted to others:

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(I) Please answer the following questions below pertaining to operational/compliance controls and protocols.

- Does the Applicant have a formalized compliance and risk management program?
- Does the Applicant have a written operational procedural manual for employees to follow?
- Does the Applicant have a formalized training program for newly hired employees?
- Does the Applicant request proof of professional liability insurance from subcontractors?
- Does the Applicant request indemnification or hold harmless agreements from sub-contractors?

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## 5. Coverage and Claims History

(a) Has any Claim and/or suit been made against any Applicant, its predecessor, or any past or present director, partner, officer, or employee?  Yes  No

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(b) Is the Applicant or any director, officer or employee thereof aware of or in possession of any knowledge of an act, error, omission, or breach of duty committed in the rendering of Professional Services that may give rise to a claim against any Insured proposed for insurance coverage under this application?  Yes  No

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(c) Has the Applicant or any of its members, employees, directors or predecessors been the subject of disciplinary proceedings?  Yes  No

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IT IS ACKNOWLEDGED AND AGREED THAT ANY LOSS ARISING FROM A MATTER DISCLOSED, OR WHICH SHOULD HAVE BEEN DISCLOSED IN 5a), 5b) or 5c) ABOVE, IS EXCLUDED FROM COVERAGE, ALL WITHOUT LIMITING ANY OTHER REMEDY AVAILABLE TO FOR NON-DISCLOSURE.

(a) Further, if the response to any part of Question 5a) is yes, please provide:

- Name of Claimant/Potential Claimant
- Date the Act, Error, Omission or Personal Injury was committed or alleged to have been committed
- Date of Claim
- Nature of Claim
- Quantum
- Any legal opinion obtained as to liability
- Any legal, adjusting or indemnity payments to date
- Any legal, adjusting or indemnity reserves established

(b) Please detail Professional Liability Insurance purchased by the Applicant for the past five years detailing the present insurance coverage first:

New  Renewal

Previous Insurer*	Policy Number	Policy Period	Policy Limit	Deductible

Previous Insurer - You must state the Insuring Company, not the Broker, of your prior Corporate Errors & Omissions Insurance.

Please state date on which uninterrupted Professional Liability Insurance began: \_\_\_\_\_

## 6. Coverage Limits and Deductible Requested

(a) Insurance Coverage Required:

1 Limit of Liability  per Claim/  per Policy Period Deductible

(b) To any Applicant's knowledge, has any insurer declined to provide or cancelled insurance coverage for any Applicant, its predecessor or any past or present director, partner, officer or employee?

Yes  No

If yes, please provide reason(s) give by such insurer:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 7. Commercial General Liability Coverage Option

Please provide a quotation for Commercial General Liability Coverage.

(a) Total estimated payroll for the next financial year: \_\_\_\_\_

(b) Are all employees covered by workers' compensation:

Yes  No

(c) Do your partners, officers, and employees use automobiles not owned by the company (applicant) on company business?

Yes  No

If yes:

Number of employee owned automobiles \_\_\_\_\_

Number of short term rentals used \_\_\_\_\_

(d) Number of clients of the company \_\_\_\_\_

(e) Do you conduct work away from the company premises?

Yes  No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1 Limit of Liability  per Claim/  per Policy Period Deductible

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## 7. Office Property Contents Coverage Option

Please provide a quotation for Office Property Contents Coverage

(a) Total value of office contents (not including portable computers/projectors) \_\_\_\_\_

(b) Total Value of portable computers/projectors: \_\_\_\_\_

(c) Is your office (or offices) equipped with a central alarm system?  Yes  No

(d) Is this office located within a residential home?  Yes  No

(e) Is this office rented/leased within a commercial property?  Yes  No

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## 8. Acknowledgements

The undersigned authorized officer on behalf of the Applicant:

- Declares that the statements and disclosures in this application are complete and accurate;
- Declares that there are no known facts material to the risk to be insured that have not been disclosed in this application;
- Undertakes to provide the Insurer immediate notice of any material changes discovered between the date of this application and the date the insurance coverage is bound or purchased;
- Acknowledges that the Insurer if it issues the policy will be doing so in reliance of the completeness and accuracy of the statements and disclosures in this application;
- Acknowledges that if issued, this application will form part of the policy.
- Acknowledges that any personal information provided in connection with the coverage applied for, including but not limited to the information contained in this application, has been collected in accordance with all applicable privacy legislation. The undersigned confirms that all necessary consents have been obtained for the collection, use, and disclosure of such information for the purposes of assessing the application for insurance, and if applicable, investigating and settling claims, detecting and preventing fraud, and acting as required or authorized by law.
- **For purposes of the Insurance Companies Act (Canada), this document was issued in the course of insurance business in Canada.**

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Signing Officer

Note: Your written signature is required for your application to be processed.