



**Burns & Wilcox Blue Ribbon Program**

**Specified Errors & Omissions Program**

Agency Name: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone number: \_\_\_\_\_  
 E-mail address: \_\_\_\_\_

Client Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_

	Street	City	County	State	Zip
Business Location:	_____	_____	_____	_____	_____
	Street	City	County	State	Zip

Applicant is:     Individual     Partnership     Corporation     Other \_\_\_\_\_

1. Business/Occupation: \_\_\_\_\_
2. Number of years in business: \_\_\_\_\_
3. Number of years of experience in this field: \_\_\_\_\_

*\*Attach job resumes of all Principals, if risk has been in operation less than 18 months.*

4. Provide a complete description of business / occupation: \_\_\_\_\_  
 \_\_\_\_\_

*\*Attach copies of brochures and contracts.*

5. Provide a complete description of any bodily contact with clients: \_\_\_\_\_  
 \_\_\_\_\_

6. Please advise the following:  
 Annual Payroll \_\_\_\_\_    Number of Participants \_\_\_\_\_  
 Annual Receipts \_\_\_\_\_    Annual Sales \_\_\_\_\_  
 Other \_\_\_\_\_

7. Applicant graduated from: \_\_\_\_\_
8. List and describe all degrees Applicant has received: \_\_\_\_\_  
 \_\_\_\_\_

- |   |           |           |
|---|-----------|-----------|
| 9. Please list number of                | Full Time | Part Time |
| A. Principals.....                      | _____     | _____     |
| B. Employees engaged in professions.... | _____     | _____     |

C. Clerical..... \_\_\_\_\_  
 D. Other..... \_\_\_\_\_  
 TOTAL \_\_\_\_\_

10. State any degree or certification achieved involving your occupation:  
 \_\_\_\_\_

11. State any special licenses or certificates required by any federal, state, or local municipality: \_\_\_\_\_

12. Are applicant, partners and employees all currently licensed?  Yes  No

13. Has your license ever been revoked or suspended?  Yes  No  
 If yes, please explain: \_\_\_\_\_

14. Has any employee ever been convicted for an act committed in violation of any law or ordinance?  Yes  No If yes, please explain: \_\_\_\_\_

15. Are you in private practice or do you operate as an employee? \_\_\_\_\_

16. Current General Liability carrier and limits: \_\_\_\_\_

17. Please advise your E&O Prior Carrier(s) for the past five years: \_\_\_\_\_

*\*Show Retro-active Date (first date of continuous Claims Made coverage):*

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

18. State past five year loss experience: \_\_\_\_\_

19. Have any claims or suits for Professional Liability been made against applicant?:  Yes  No If yes, please explain: Date of loss: \_\_\_\_\_  
 Circumstances of claims \_\_\_\_\_

Reserve and/or payment, expenses: \_\_\_\_\_

20. Has any carrier refused renewal, cancelled, or declined applicant's request for coverage?  Yes  No If yes, please explain: \_\_\_\_\_

21. State any professional organization membership: \_\_\_\_\_

*\*Any continuing education?* \_\_\_\_\_

22. Limits of Liability desired: \_\_\_\_\_

23. Desired policy term: From \_\_\_\_\_ To \_\_\_\_\_

In your own words please describe circumstances which would give rise to a claim under the coverage for which you are applying for: \_\_\_\_\_

24. Optional general liability requested?

Yes  No If yes, limits will be the same level as E&O. If bound, need Acord application.

25. Any additional information: \_\_\_\_\_

This applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance. Any insurance contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy. A signed application dated not more than 30 days prior to the inception date will be required in the event coverage is effected.

Agent: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

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

\_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_