INSTRUCTIONS:

1. Please answer all questions, leave no blank spaces.
2. If space is insufficient to answer fully any questions, attach separate sheet or email.
3. Include a copy of each court appointment.

PARENTING COORDINATOR MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION

QUOTED INDIVIDUALLY BY THE UNDERWRITERS

THIS PROPOSAL FORM IS FOR A POLICY THAT IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED WHILE THE POLICY IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

1. Name of Applicant (Mr. Ms. Dr.): _____

2. Physical Address of the Head Office: _____

   _____

3. Phone Number (_____)_____ Fax Number (_____)_____

   Email Address _____

   Mailing Address _____

4. When was the firm established: _____

5. Application is: ☐ corporation ☐ partnership ☐ individual If individual, is this a full time activity? ☐ **Yes** ☐ **No**

6. Please describe in detail the professional activity for which coverage is desired: _____

   _____

   _____

   _____

   _____

7. List the total gross revenues for the past year, current year and projection for the coming year derived from those activities described in Question 6:

   Past year _____ Current year _____ Projection for coming year _____

8. Please provide the following:

Name in full of all principal partners/ key employees:	Professional Qualifications:	How long with firm:

9. Total Staff:

   Principals/Partners: _____ Key Employees: _____ Non-Professional Employees: _____

10. Does the applicant use a written contract with clients? ☐ **Yes** ☐ **No**
Please attach a copy of your standard contract.

11. To what professional organizations does the Applicant belong?:

_____

_____

_____

_____

_____

12. What percentage of your business involves subcontracting work to others?: _____

13. Does any one client represent more than 10% of your income? ☐ **Yes** ☐ **No**
If yes, give full details:

_____

_____

_____

_____

14. Is similar insurance in force? ☐ **Yes** ☐ **No**
If yes, please provide:

Policy Number	Carrier	Limits of Liability	Deductible	Premium

_____

_____

_____

Date uninterrupted coverage began: _____

15. Has any proposal for similar insurance made on behalf of the firm, any predecessors in business or present partners even been declined or has any similar insurance ever been cancelled or refused? ☐ **Yes** ☐ **No**
If yes, please give full details

_____

_____

_____

16. Have any of the individuals listed in Question 8 ever been subject of disciplinary action by authorities as a result of their professional activities? ☐ **Yes** ☐ **No**
If yes, please explain:

_____

_____

_____

17. Has any claim ever been made against the applicant or any entity named in Question 1 or against their predecessors in business or against any past or present principal, partner, director, officer or employee of any entity named in Question 1? ☐ **Yes** ☐ **No**

If yes, state briefly the cause and nature of the claim including the amount involved, the date when the claim was made, the date the act giving rise to the claim was committed and the final dispositions:

_____

_____

_____

18. Is the applicant aware of any circumstances that may result in a claim against him/her or against any entity named in Question 1, or against their predecessors in business, or against any past or present principal partner, director, officer or employee of any entity named in Question 1? ☐ **Yes** ☐ **No**
If yes, please give full details:

_____

_____

_____

19. Please attach a copy of your resume and brochure or any promotional material used.

20. Coverage requested:

Limit of Liability: $_____

This limit shall include loss payments, if any, as well as adjustment, investigative and legal fees, costs, charges and expenses

Deductible: $_____

This deductible includes loss payments, and adjusting, investigative and legal fees, costs and expenses, whether or not loss payment is involved unless otherwise stated.

I/WE (APPLICANT) DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO FACTS HAVE BEEN SUPPRESSED OR MIS-STATED AND AGREE THAT THIS APPLICATION FORM SHALL BE THE BASIS OF ANY POLICY OF INSURANCE WHICH MAY BE ISSUED BY UNDERWRITERS AND SHALL BE DEEMED A PART THEREOF. IN ADDITION, APPLICANT AGREES AND ACKNOWLEDGES THAT IF APPLICANT, SUBSEQUENT TO THE COMPLETION OF THIS PROPOSAL, BECOMES AWARE OF ANY CHANGES IN THE STATEMENTS AND PARTICULARS CONTAINED HEREIN, THAT PROPOSER SHALL IMMEDIATELY ADVISE UNDERWRITERS OF SUCH CHANGES. IT IS FURTHER UNDERSTOOD AND AGREED THAT UPON RECEIPT OF SUCH SUPPLEMENTAL ADVICES, UNDERWRITERS MAY ALTER, AMEND THE TERMS OR WITHDRAW ANY QUOTATION PREVIOUSLY OFFERED.

Signature of Applicant: _____

Dated: _____

Title: _____

It is agreed that the signature to the form does not bind the Underwriters nor the Proposer to complete this insurance.

Please return completed and signed application to:

Complete Equity Markets, Inc.
In California dba Complete Equity
Markets Insurance Agency, Inc. (CASL#0D44077)
1190 Flex Court
Lake Zurich, IL 60047
www.cemins.com
(800) 323-6234 Toll Free
(847) 541-0900 In Illinois
(847) 541-0444 FAX