

# PREMIUM INDICATION REQUEST

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State ZIP

Mailing Address: \_\_\_\_\_  
Street Address City State ZIP

Fax Number: (\_\_\_\_) \_\_\_\_\_

**YES!** I would like a premium indication for Lawyers Professional Liability Insurance to cover:\*

- Court Appointed Work Only
- Private Practice (for combination appointed and private)
- Part-Time Private Practice. (Please provide Gross Income: \$ \_\_\_\_\_)

My practice is (using time devoted):

\_\_\_\_% Criminal Defense (court appointed and privately retained)

\_\_\_\_% Other (provide breakdown of other by percentage)

\_\_\_\_% \_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_% \_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_ Solo Practice \_\_\_\_ Corporation \_\_\_\_ Partnership

Number of years in practice: \_\_\_\_\_

Number of attorneys in office: \_\_\_\_\_

Currently insured with a policy expiring \_\_/\_\_/\_\_

Retroactive date on expiring policy (date showing the amount of prior acts coverage carried) \_\_/\_\_/\_\_

Have you ever had a claim/suit/disciplinary complaint brought against you or been provided with notice of a potential claim/suit/disciplinary complaint? \_\_\_\_\_

If yes, please include a brief description of the allegations and the outcome of the matter.

Please fax or mail this form to us today for your premium indication.

\*Indications of premium only. Completed application would be required to verify indications and effect coverage.

\_\_\_\_\_  
*Name*

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## Complete Equity Markets, Inc.

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Criminal Defense Lawyers Professional Liability Insurance Program  
for NACDL Members  
1190 Flex Court  
Lake Zurich, IL 60047  
Toll Free: (800)323-6234 In Illinois: (847)541-0900  
Fax: (847)541-0444

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