

LEGAL NURSE CONSULTANTS PROFESSIONAL LIABILITY

(This is an application for claims made coverage)

This is an application for claims made coverage with limits of liability which can be eroded wholly or partially by claim expenses.

If there is any question, please consult with your agent, broker, or attorney

- A) Please type answers to all questions, leaving no blank spaces.
- B) The application must be signed and dated.
- C) When answering questions, please use a separate sheet of paper if space provided is insufficient.
- D) - PLEASE TYPE -

1. Name of Applicant _____
 Street Address _____
 City _____ State _____ Zip Code _____
 Area Code/Phone Number _____ FAX Number _____
 Email Address _____ Website _____
 Mailing Address _____
 (State) _____ (Zip) _____

Applicant is: Partnership Individual Corporation Other (Please specify) _____

2. Is your legal nurse consulting work done on a full or part-time basis? Full-time Part-time

If Part-time, do you work full-time? Yes No What is your occupation? _____

Annual income from full-time occupation: 0 - \$20,000 \$20,001 - \$40,000 \$40,001 - \$60,000 Over \$60,000

3. List Branch Offices and Addresses, if any:

- 1. _____
- 2. _____

4. a) Total number of consultants. _____ b) Total number of cases and/or files handled annually. _____
 (An estimate may be used if an accurate count is not available.)

Concerning the above, how many result in court appearances? _____

5. a) State gross income derived from services as a Legal Nurse Consultant for the past 12 months. \$ _____

b) State estimated gross income derived from services as a Legal Nurse Consultant for the next 12 months. \$ _____

6. Please provide the following information:

List names of all Legal Nurse Consultants providing professional services on behalf of the Applicant:
(If contractors, please state number of hours they performed these services for the Applicant in the past 12 months)

_____	_____
_____	_____
_____	_____

PLEASE SEND A COPY OF RESUME(S).

7. What is the Applicant's area of expertise? _____

Please furnish background information on this area of expertise (use a separate sheet if necessary). _____

(Please attach Brochure or other similar material)

8. How many years has the Applicant been providing services as a Legal Nurse Consultant? _____

9. Please list membership in any professional association. _____

10. Please provide a detailed description of a common forensic case that you have worked on. (use a separate sheet if necessary).

11. Does the Applicant maintain any other type of professional liability and/or malpractice insurance? Yes No

If Yes, please furnish:

Type of Coverage: _____ Name of Carrier: _____

Limits of Liability: _____ Policy Period: _____

12. Has any similar insurance for the applicant ever been cancelled or declined? Yes No

If Yes, please furnish all pertinent details (use a separate sheet if necessary) _____

13. Has any Disciplinary Proceeding ever been instituted against the Applicant by any court, or committee or board thereof, or commission established by constitutional provision, statute, or court rule to investigate, review or impose disciplinary sanctions for charges of misconduct? Yes No

If Yes, please give full details. _____

14. Have any claims or suits been made during the past ten years against the Applicant either as an individual or as a Legal Nurse Consultant or Partner of any other firm? Yes No

If Yes, please give full particulars. _____

15. Is the Applicant aware of any circumstances which may result in any claim being made against the Applicant? Yes No

If Yes, please give full details. _____

16. Limits of Liability Requested:

- \$100,000/100,000 \$250,000/250,000 \$500,000/500,000 \$1,000,000/1,000,000
 \$1,000,000/2,000,000

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Deductible Requested:

- \$1,500 \$2,500 \$5,000 \$7,500 \$10,000 \$ _____

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PLEASE SEND A COPY OF RESUME(S).

The applicant declares and warrants that, after enquiry, to the best knowledge of all persons to be insured the statements set forth herein and in any attachments made hereto are true and no material facts have been suppressed, omitted or misstated. Underwriters reserve the right to deny or rescind coverage on any Policy, Certificate or Evidence of Insurance that is issued as a result of this Application, if, in the statements set forth herein and any attachments made hereto it is found that material information has been omitted, suppressed or misstated.

Underwriters also reserve the right to amend the terms, conditions and limitations, coverage of any Policy, Certificate or Evidence of Insurance that is issued as a result of this application, if subsequent to the date of this application, but prior to the inception date of such policy, there are any material alterations to the information contained herein. In the event of such material alteration, as aforesaid, the Applicant agrees to give immediate written notice to Underwriters and such notice shall attach to and form part of this application.

Signing this application does not bind the Applicant or Underwriters to complete the Insurance, but it is agreed that the statement and particulars contained herein will be relied upon by Underwriters should a Policy, Certificate or Evidence of Insurance be issued.

This application is signed on behalf of all Owners, Partners, Shareholders, Corporate Officers and Employees.

Complete Equity Markets, Inc.
1190 Flex Court
Lake Zurich, Illinois 60047
(800)323-6234
(847)541-0900
(847)541-0444 (Fax)

Name of Applicant _____
(Please Print)

Signature _____

Date _____

This Proposal Form duly completed, together with any supplementary information, must be signed in ink by the Applicant. A signed copy will be attached to and form part of the Policy, Certificate or Evidence of Insurance, if issued. **Completion of this Proposal Form does not bind or obligate the Applicant to complete this insurance.**

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