

# Insurance Agency E & O Quick Quote Form

BOSWELL INSURANCE AGENCY - E & O DIVISION

1. Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
 Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_ Date Established: \_\_\_/\_\_\_/\_\_\_ Number of Locations: \_\_\_  
 Number of Licensed Producers \_\_\_\_\_ Non-Licensed Staff \_\_\_\_\_ Independent Contractors: \_\_\_\_\_ Do you want them covered? \_\_\_\_\_

2. Limits of Liability desired: \_\_\_\_\_ Deductible desired: \_\_\_\_\_

3. a. Please indicate the premium volume produced by or through the Applicant and the revenues earned by the Applicant, and the Applicant's policy count during the years listed below:

Year	P & C Premium Volume	P & C Revenue	Life & Health Commission	
Last 12 Mos.	\$ _____	\$ _____	\$ _____	
Next 12 Mos.	\$ _____	\$ _____	\$ _____	

b. Does the Applicant receive income from any additional services? \_\_\_\_\_ If "Yes", please attach a description.

4. a. Please indicate the percentage of business placed as a: Retail Agent \_\_\_\_\_% Broker \_\_\_\_\_% Wholesaler \_\_\_\_\_% MGA \_\_\_\_\_%  
 b. Please indicate either the dollar amount or percentages of the Applicant's premium volume derived from each line of business listed below (if using percentages, the total of all lines should equal 100%):

Personal Lines	Commercial Lines
Auto (Standard)	Auto (Other than Long Haul Trucking)
Auto (Non-Standard)	Long Haul Trucking
Homeowners/Umbrella	Business Owner's Policy
Personal Marine	General Liability & Property (non-BOP)
<b>Life, Accident, and Health</b>	Workers Comp
Individual Life	Crop
Individual Accident and Health	Bonds
Group Life	Aviation
Group Accident and Health	Ocean Marine
Pension Plans	Inland Marine
Mutual Funds	Professional Liability/Medical Malpractice
Annuities	Other (Describe)

5. Please list the top three (3) insurers (including companies, syndicates, captives, etc.) and MGAs with which the Applicant has placed business during the past three (3) years:

Insurers and/or MGAs	Premium Volume	Admitted? (Y or N)
	\$	
	\$	
	\$	

6. Does the Applicant currently have errors and omissions in force? \_\_\_\_\_ If "yes", are you being renewed? \_\_\_\_\_  
 Name of Insurer: \_\_\_\_\_  
 Limit: \_\_\_\_\_ Deductible: \_\_\_\_\_ Premium: \_\_\_\_\_  
 Current Retroactive Date (if full, first date of continuous E&O coverage): \_\_\_/\_\_\_/\_\_\_ Expiration Date: \_\_\_/\_\_\_/\_\_\_

7. a. Has the Applicant been the subject of disciplinary action or investigation as a result of professional activities? \_\_\_\_\_  
 b. Have there been any errors and omissions claims made during the past five (5) years? \_\_\_\_\_  
 c. Does the Applicant have any knowledge of any potential errors or omissions claim(s)? \_\_\_\_\_  
 If "Yes" to (b) or (c), please fill out Claim Information form on following page.

**Office Procedures Questionnaire**

- a. Are copies of binders mailed to insured and/or the company promptly? Yes No
- b. Is there a procedure for documenting phone conversations? Yes No
- c. Is a policy expiration list maintained? Yes No
- d. Are all policies and endorsements checked for accuracy? Yes No
- e. Does agency have a diary/suspense system? Yes No
- f. Does applicant have an Office Procedures Manual? Yes No
- g. Does applicant document a client's refusal to accept coverage/limits limitations? Yes No
- h. Does agency utilize a computerized production and accounting system? Yes No
- i. Is incoming mail date stamped? Yes No
- j. Are binders confirmed in writing? Yes No

1. Do you act as a TPA? If so for what program and what authority do you have?

2. Do you have any claims authority? If so, how much?

**Claim Information**

Please either complete this form or send a loss run for each claim within the last 5 years.

Name of Claimant: \_\_\_\_\_

Date of Alleged Error: \_\_\_\_\_ Date Reported to E & O Carrier: \_\_\_\_\_

Name of E & O Carrier: \_\_\_\_\_

Is this claim    Open    Closed

If Closed:

The total paid for damages or loss \$ \_\_\_\_\_

The total of claim expenses/defense costs in excess of the deductible \$ \_\_\_\_\_

If Open:

The total paid for damages or loss \$ \_\_\_\_\_

The total of claim expenses/defense costs in excess of the deductible \$ \_\_\_\_\_

Reserves \$ \_\_\_\_\_

Details of the current status: \_\_\_\_\_

\_\_\_\_\_

Description of the claim, type of coverage involved and the alleged act, error, or omission:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

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