Legal Aid / Public Defender Program
LAWYERS PROFESSIONAL LIABILITY INSURANCE
Public Entity / Organization New Business Application

1. APPLICANT INFORMATION

a.) Legal Name of Organization / Entity to be Insured _____

b.) Primary address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Facsimile Number:_____

Email Address: _____ Website: _____

c.) To whom should correspondence regarding this Application and/or related insurance matters should be directed?

Name:_____ Title: _____

Preferred method of communication Fax ☐ Email ☐ Regular Mail ☐

d.) Are there entities or programs related to the applicant for whom coverage is requested? ☐Yes ☐ No

If yes, please list and explain relationship on a separate sheet.

e.) Please check the following category(s) that best describes the Applicant:

- ☐ Civil Legal Services Organization
- ☐ Public Defender Agency
- ☐ Pro Bono Program
- ☐ Legal Clinic/Law School
- ☐ Other (Please describe) _____
- ☐ Contract Defender
- ☐ Assigned Counsel (Court Appointed)
- ☐ Public Interest, Civil Rights/Liberties or Social Service
- ☐ Advocacy Group

2. CLIENT and STAFF INFORMATION

a.) What percent of the Applicant's cases are for clients who are **not** indigent and whose incomes are more than 200% above the national poverty level?

☐ 0% ☐ 5% ☐ 10% ☐ 20% ☐ 25% ☐ > 25%

b.) Does the Applicant provide any services for clients other than legal? ☐Yes ☐ No

c.) Please provide the number of attorneys on staff whose average # of weekly work hours is:

1 – 10 hours	11 – 20 hours	20 - 35 hours	35+ hours

d.) What is the total number of hours of legal services provided *annually* by all volunteer attorneys on behalf of the applicant? _____hrs.

e.) Are all attorneys (staff and volunteer) admitted to practice law in the state in which they are providing legal services on behalf of the organization? ☐Yes ☐ No

f.) If not, is the organization in compliance with the state bar regulations regarding practicing attorneys? ☐Yes ☐ No

g.) Type of legal services provided (check all that apply)

- ☐ Criminal ☐ Family ☐ Healthcare ☐ Immigration
- ☐ Housing ☐ Bankruptcy ☐ Consumer Rights ☐ Veterans Assistance
- ☐ Elder Law ☐ Civil Rights ☐ Other (describe) _____

3. CLAIMS INFORMATION

a.) Has any professional liability claim or suit been made in the past 5 years against any current or former attorney, employee, member or volunteer of the Applicant and/or the Applicant itself or any predecessor entity? ☐Yes ☐ No

b.) After inquiry, does any individual attorney, employee, member or volunteer of the Applicant have knowledge or information of any occurrence or incident which may give rise to a claim? ☐Yes ☐ No

c.) Within the past five years, has any attorney been subject to any disciplinary inquiry, complaint or proceeding for any reason other than non-payment of dues? ☐ Yes ☐ No

If "yes" has that attorney been refused admission to practice, disbarred, suspended, formally reprimanded, or sanctioned in any other way? ☐ Yes ☐ No

d.) Have all matters noted in response to 3.a), 3.b) and 3.c) above been reported to the Applicant's current insurer or to the current insurer of any predecessor entity or to the current insurer of any attorney of the Applicant? ☐Yes ☐ No

If the answer to questions 3.a), 3.b) or 3.c) was "Yes", please complete the Claims / Disciplinary Supplemental Application for each claim, incident or disciplinary matter.

4. CURRENT COVERAGE INFORMATION

a.) Is the applicant currently insured for malpractice insurance? ☐Yes ☐ No

b.) If yes, please provide the following and attach a copy of your current declarations page in order to quote comparable coverage:

Policy Expiration Date	Insurance Carrier	Limit	Deductible	Total Policy Premium

c.) Prior acts date on current policy: _____/_____/_____

d.) Has headcount (including total annual volunteer hours) changed in the past year? ☐ Yes ☐ No

e.) Optional Coverages

☐ ☐Management Liability Errors & Omissions

☐☐ Employment Practices Liability *provide Limit of Liability* _____

☐☐ Primary Pro Bono

☐☐ Punitive Damages

☐ ☐Criminal Defense

☐ ☐Other (Please describe) _____

NOTICE: If a policy is issued, it will be on a claims made and reported form. The limit of liability will be reduced by payments of judgments, settlements and/or damages, as well as defense costs and/or claims expenses as specifically provided in such policy. The deductible or retention will be reduced by payments of judgments, settlements and/or damages as specifically provided in such policy.

5. COVERAGE REQUESTED

Please indicate coverage for which a quote is requested

a.) Professional Liability limit (each claim/in the aggregate):

□ $100,000/$300,000 □ $250,000/$500,000 □ $500,000/$500,000

□ $1,000,000/$1,000,000 □ Other (Specify): _____

b.) Deductible:

□ $1,000 □ $2,500 □ $5,000 □ Other (Specify): _____

(Note: Deductible applies separately to each coverage part and includes Defense Costs.)

c.) Optional Coverages:

□□ Management Liability Errors & Omissions *(Please complete Supplemental Application Form)*

□□ Employment Practices Liability *(Must purchase Management Liability E&O to be eligible for coverage - Please complete the Supplemental Application Form)*

□ $50,000 / $150,000 □ $100,000 / $300,000 □ $250,000 / $500,000

□ $500,000/$500,000 □ $1,000,000/$1,000,000

□□ Primary Pro Bono

□□ Outside Practice of Law

□□ Punitive Damages (50,000/50,000 sublimit)

□□ Criminal Defense (50,000/50,000 sublimit)

□□ Injunctive Relief (50,000/50,000 sublimit)

□□ Other (Please describe) _____

c.) Is the Applicant contractually required to name any Additional Insured on the policy? ☐Yes ☐ No

If yes, please provide the following information for each Additional Insured required and attach a copy of the current contract with those requirements.

a. Additional Insured's Name: _____

Principal business address: _____

City: _____ State: _____ Zip Code: _____

b. Does this Additional Insured require advanced notice if insurance policy is cancelled? ☐Yes ☐ No

The undersigned Applicant, Chief Executive Officer, Executive Director, or officer acting on behalf of the Applicant and all proposed insureds, hereby declares after diligent inquiry that the above statements and particulars including any statement or particulars in any supplemental applications or forms required hereby are true, accurate and complete and that no material facts have been suppressed or misstated.

Signature: _____ Date: _____

Print Name: _____ Title: _____

(Must be signed by the Chief Executive Officer, Executive Director or Officer of the Applicant)

Please return completed application to:

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SUPPLEMENTAL APPLICATION FORM

Management Errors & Omissions / Employment Practices Liability coverage

1. Applicant Name: _____

2. What is the Applicant's total number of employees including full time, part-time and volunteers?

Full-Time	Part-Time	Volunteers

3. Have more than 25% of the organizations employees been terminated in the last year, or are they expected to be terminated in the upcoming year? ☐Yes ☐ No

4. Does the Applicant have written guidelines or procedures for addressing human resource personnel management issues? ☐Yes ☐ No

5. If no such written guidelines or procedures exist please describe how decisions regarding human resource personnel management issues are made:

   _____

4. After inquiry, does the Applicant and/or any individual lawyer, employee, member or volunteer have any knowledge or information of any inquiry, investigation, grievance filing, other administrative hearing, claim or suit made during the last five years before any Local, State or Federal court or agency governing employer responsibility to employees? ☐Yes ☐ No

   If yes, please complete a Supplemental Claim Form for each incident

5. After inquiry, does the Applicant and/or any individual lawyer, employee, member or volunteer have any knowledge or information of any act, error or omission which might give rise to a claim under Management Errors & Omissions Coverage and/or Employment Practices Coverage, including Wrongful Termination, Discrimination, Sexual Harassment or other similar human resource related claims? If yes, please complete a Supplemental Claim Form for each incident. ☐Yes ☐ No

   Note: It is understood that if such knowledge and information exists, any claim or action arising therefrom is excluded from coverage thereunder.

6. Have all matters noted in response to Questions 4 and 5 above been reported to Applicant's current insurer or to the current insurer of any predecessor entity or to the current insurer of any attorney of Applicant? ☐Yes ☐ No

The undersigned Applicant, Chief Executive Officer, Executive Director, or officer acting on behalf of the Applicant and all proposed insureds, hereby declares after diligent inquiry that the above statements and particulars including any statement or particulars in any supplemental applications or forms required hereby are true, accurate and complete and that no material facts have been suppressed or misstated.

Signature: _____ Date: _____

Print Name: _____ Title: _____

(Must be signed by the Applicant, Chief Executive Officer, Executive Director or Officer of the Applicant)

Please return completed application to:

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