

## The Association of TeleServices International Professional Liability (E&O) Program

### Alliant Insurance Services

4530 Walney Road, Suite 200  
Chantilly, VA 20151

Toll free: 855-393-ATSI (2874) Email: [renee.green@alliant.com](mailto:renee.green@alliant.com)  
Fax: 703-563-1510 [rey.lavilla@alliant.com](mailto:rey.lavilla@alliant.com)

Insurance Application

This is an application for a Claims Made Policy

THE ANSWERS TO THESE QUESTIONS FORM PART OF AN APPLICATION FOR INSURANCE ONLY. NOTHING IN THIS APPLICATION SHALL BE DEEMED AN AGREEMENT TO PROVIDE INSURANCE AND UNDERWRITERS MAY DECLINE TO OFFER COVERAGE OR OFFER COVERAGE ON TERMS THAT DIFFER FROM THE COVERAGE SOUGHT BY THE APPLICANT.

The coverage for which the applicant is applying is written on a claims made basis. Only claims first made against the Assured during the period of insurance are covered, subject to policy terms and conditions. The limits of liability stated in the evidence of insurance are reduced by costs of defense. Costs of defense will also be applied to the deductible. If you have any questions about the coverage, please discuss them with your broker

**DOWNLOAD AND SAVE APPLICATION TO COMPUTER FIRST, THEN COMPLETE. APPLICATION IS FILLABLE.**

### SECTION 1: INSURANCE

Do you currently have Professional (E&O) Insurance?  Yes  No If Yes, Policy #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Retroactive Date: \_\_\_\_\_ Carrier: \_\_\_\_\_  
(Date your 1st policy was effective)

Are you an ATSI Member?  Yes  No If Yes, provide membership#: \_\_\_\_\_

Number of Employees: \_\_\_\_\_

#### Your Details

Contact Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Name: \_\_\_\_\_

Location Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Provide a list of subsidiaries to be insured by this policy (or attach list to application):**

### SECTION 2: STANDARD COVERAGE OPTIONS

Please enter your total gross income for the previous 12 months: \$  
(Startups must furnish projected figure for first year)

Does or has the applicant provided any form of answering services to any of the following: Medical Doctors and / or other health care providers giving direct medical care to humans, or to any other medically related operations or practices (dentists, veterinarians, ambulances, other emergency services, oxygen supply companies etc.) Yes No

If yes, please enter the total % and total \$ amount of your income that is derived from these services: % \$

Do you derive any income from monitoring Alarms or Protective systems? Yes No

If yes, please enter the total % and total \$ amount of your income that is derived from these services: % \$

Do you derive any income from Life-Line Response Services? Yes No

If yes, please enter the total % and total \$ amount of your income that is derived from these services: % \$

**SECTION 3: CLAIMS QUESTIONS**

Have any claims or suits ever been made against the Applicant or Applicants' firm, or any person now a principal or owner of the Applicants' firm, or any predecessor entity or any prior entity owned or previously owned by a current principal or owner of the Applicant firm:

Yes      No

If Yes, please provide full details including date, claimant's name(s) and amounts paid for both settlement and defense:

Upon inquiry of all personnel, is the Applicant, or any employee, manager or owner of the Applicants firm, aware of any circumstance, incident or situation, which may result in a claim?

Yes      No

If yes, please provide details:

Has any similar insurance for the Applicant or Applicants' firm or any person now a principal or owner of the Application or Applicants' firm, or any predecessor entity or any prior entity owned or previously owned by a current principal or owner of the Applicant or Applicants' firm ever been canceled or declined or refused renewal?

Yes      No

If Yes, please provide full details:

**SECTION 4: DECLARATION**

I/ WE (THE APPLICANT) DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO FACTS HAVE BEEN SUPPRESSED OR MIS-STAED AND AGREE THAT THIS APPLICATION FORMS SHALL BE THE BASIS OF ANY POLICY OF INSURANCE WHICH MAY BE ISSUED BY UNDERWRITERS AND SHALL BE DEEMED A PART THEREOF, IN ADDITION ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE TO THIS APPLICATION AND MADE PART HEREOF, FURTHERMORE, THE APPLICANT AGREES AND ACKNOWLEDGES THAT IF THE APPLICANT, SUBSEQUENT TO THE COMPLETION OF THIS APPLICATION, BECOMES AWARE OF ANY CHANGES TO THE STATEMENTS AND PARTICULARS CONTAINED HEREIN, THAT THE APPLICANT SHALL IMMEDIATELY ADVISE UNDERWRITERS OF SUCH CHANGES, IT IS FURTHER UNDERSTOOD AND AGREED THAT UPON RECEIPT OF SUCH SUPPLEMENTAL, UNDERWRITERS MAY ALTER, AMEND THE TERMS OR WITHDRAW ANY QUOTATION PREVIOUSLY OFFERED.

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

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

Electronic (Typed) Signature is Acceptable.