Professional Liability Insurance Application for Nondestructive Testing Consultants

Questions?
Contact: Christine So
Toll free: (703) 547 - 6296
Email: Christine.So@alliant.com

Alliant Insurance Services, Inc.
4530 Walney Road
Suite 200
Chantilly, VA 20151

Section 1: Applicant

Contact Name: _____ Email: _____

Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Business Telephone: _____ Home Telephone: _____ Cell No: _____ Fax No: _____

Are you and your employees members of ASNT? Yes ☐ No ☐

Please list all of the staff (including partners/officers/principles), listing their job roll and their ASNT Certification levels.

_____

List related trade organization memberships: _____

Please provide ASNT member number: _____

Section 2: Company Background

a) Indicate firm type:
☐ Corporation ☐ Partnership
☐ Sole Proprietorship ☐ Joint Venture

b) If an individual, are you:
☐ Full Time ☐ Part Time (Moonlighting – if part time, must be employed elsewhere fulltime)

c) Does the Applicant have:
☐ Subsidiaries ☐ Parent Company ☐ Other Related or Affiliated Entities

If yes please describe _____

d) Periods for financial year end. Revenue figures must be provided in order to provide a quote. If you do not have a full year of gross revenues please provide revenue projection for a complete 12 month fiscal year. Please note carrier may request to review annual revenue statements.

Gross billings, sales, fees, and commissions			
	Previous 12 Months	Current 12 Months	Next 12 Months

e) Please list below the services provided, the corresponding percentage of annual gross revenue and the subcontracted revenue:
(if you are not yet in business, please give an estimate of your anticipated breakdown after the first year in business)

Services

i) Please describe areas of Testing Services below stating the % of income derived from each service and a description of each.

a. ☐ %

b. ☐ %

c. ☐ %

d. ☐ %

Total (should be 100%) 0 %

*Please include any additional information below:

	Yes	No
f) Do you utilise Subcontractors/Independent Contractor?	☐	☐
g) Are certificates of insurance required from these Subcontractors/ Independent Contractor?	☐	☐

h) If yes, what are the minimum requirements?

General Liability $ ☐

Professional Liability $ ☐

	Yes	No
i) Are subcontractors/ Independent Contractor hired under written contract?	☐	☐
j) If yes, do contracts contain hold Harmless or indemnification provisions in favour of the Applicant?	☐	☐

k) Staff:

Total staff, personnel of Applicant

Partners/Officers/Principals	☐
Technical	☐
Clerical	☐
Total	☐

Section 3: Operations

a)Briefly describe your largest job during the past three years: (if you're not yet in business please enter 0.)

Contract Value: ☐ Scope of Work: ☐

NOTE: If you are not yet in business, please answer as if you were in business:

		Yes	No
a)	Are written contracts or agreements always used in describing the services the Applicant will provide?	☐	☐
b)	If microbial work is performed, do contracts contain specific limitations, protections or disclaimers related to this type of work?	☐	☐
c)	Do all contracts contain hold harmless or indemnity agreements to the Applicant's benefit?	☐	☐

Section 4: Coverage

a) Please provide prior carrier information for the last three (3) years:

i) Professional Liability:

Expiration Date	Carrier	Policy #	Limits	Deductible	Total Premium

ii) Do you currently carry general liability insurance? If yes, provide details (Insurer, limit of liability).

a. Insurer ☐

b. Liability Limit ☐

iii) Please indicate desired Professional Liability limit and deductible options you desire indications for:

Limit:

- ☐ $1,000,000 / $1,000,000
- ☐ $1,000,000 / $2,000,000
- ☐ $1,000,000 / $3,000,000
- ☐ $2,000,000 / $2,000,000
- ☐ Other (Specify) _____

Deductible:

- ☐ $2,500
- ☐ $5,000
- ☐ $10,000
- ☐ Other (Specify) _____

Section 5: Claims Experience

a) Have any claims, suits or proceedings been made during the last five years against the Applicant, or Applicant's predecessors in business, subsidiaries or affiliated companies or against any of their past or present partners, owners, officers, sales persons or employees?

Yes ☐ No ☐

If yes, please complete the following Claims Supplement Form

b) Is the Applicant aware of any actual or alleged fact, circumstance, situation, error or omission which may reasonably be expected to result in a claim being made against them or any of the persons associated with the Applicant?

Yes ☐ No ☐

If yes, please complete the following Claims Supplement Form

Section 6: Supplementary Information

Please be prepared to provide the following information as part of this application:

1- Brochure/ Statement of Qualifications
2- Current fiscal statement
3- Resumes of key personnel
4- Copy of a standard contract

The applicant declares that, after inquiry, 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 amend the terms, conditions and limitations of any policy issued as a result of this application, if subsequent to the date of this application, but prior to the date of such policy, there are any material alterations to the information contained herein. In the event of such material alteration, as foresaid, the Applicant agreed to give immediate written notice to Underwriters and such notice shall attach and form part of this Application.

Submitting this Application does not bind Underwriters to complete this insurance, but it is agreed that the statements and particulars contained herein will be relied upon by Underwriters should a policy be issued.

This Application is submitted on behalf of all owners, principles, partners, shareholders, directors and employees:

I/We hereby declare that the above statements and particulars are true and that I/we have not supressed and material facts and I/we agree this declaration shall be the basis of the contract between me/us and the Underwriters.

SUBMITTING THIS FORM DOES NOT BIND THE APPLICANT TO COMPLETE THE INSURANCE. HOWEVER, IF COVERAGE IS BOUND, THIS APPLICATION BECOMES PART OF THE POLICY.

Effective Date Requested for this Insurance: _____

Signature: _____ Date _____

Supplemental Claims Application Form (If Applicable)

Full name of individual(s) and name of firm involved in claim: _____

Date of alleged error/ occurrence: _____

To which insurance Company did you report this claim? _____

Date reported to insurance company: _____

Present status of claim? ☐ Open ☐ In suit ☐ Closed

Total damages paid/ outstanding: _____

If pending: Amount asked in summons: $ _____
Claimants settlement demand: $ _____
Defendant's offer of settlement: $ _____

Description of claims, case and events: (attach necessary documents if available)

1) Do you currently have a Laboratory Liability coverage in place? Yes ☐ No ☐
If yes, please provide pertinent details:

Signed _____ Date _____

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