



**LAWYERS'
MUTUAL**
INSURANCE COMPANY

**Individual Application
Association Referral Service Program Application
Claims Made & Reported Policy**

ATTENTION! This application will be considered only if accompanied by a sample of your letterhead.

GENERAL INFORMATION

Full Name of Applicant: _____ Individual Corporation

Full Primary Address: _____

Primary Contact Number: _____ Primary Fax Number: _____

Primary Contact Email: _____ Website Address: _____

Is Applicant Lawyer a sole practitioner? Yes No

If No, please state name of Firm which employs Applicant and total number of lawyers employed by this firm:

Firm Name: _____ Total No. of Lawyers: _____

Date Established: _____ Effective Date Requested: _____

Legal Education:

Law School _____ State Bar Number _____ Admission Date _____
Mo/Day/Year

UNDERWRITING INFORMATION

Name(s) of approved Lawyers' Mutual Insurance Company Bar Association and Lawyer Referral Service:

A) _____ B) _____ C) _____

1. Has the Applicant, and/or the law firm which employs this Lawyer ever had any policy of professional liability insurance non-renewed, declined or cancelled? If yes, explain on a separate sheet. ___ Yes ___ No

2. Does the Applicant for whom coverage is sought have knowledge of any error, omission, or disagreement with any client which might reasonably give rise to a claim or suit against the Lawyer or the law firm which employs this Lawyer? If yes, explain on a separate sheet. ___ Yes ___ No

3. Has the Applicant and/or the law firm which employs this Lawyer, ever had any claim made against them during the past 10 years alleging any liability arising from the performance of professional services? ___ Yes ___ No If yes, how many? _____
Note: Page 3 of the application must be completed and returned for each claim. If no claim(s), Page 3 must still be signed, dated and returned

4. a. Has any disciplinary proceeding ever been brought by The State Bar of California against the Applicant? ___ Yes ___ No
If yes, how many? _____

b. Has the Applicant ever been reprimanded by or refused admission to practice, disbarred or suspended from practice before any court or administrative agency? If yes, explain on a separate sheet. ___ Yes ___ No

5. Does the Applicant utilize a calendar control system? ___ Yes ___ No If yes, to whom is responsibility for entry assigned? If no, explain: _____
Is the system computerized? ___ Yes ___ No

Does the ultimate responsibility for calendar control of litigation rest with the Lawyer who is handling the case? ___ Yes ___ No

Describe the manner in which the Lawyer who is handling the case is notified of a matter on their calendar: _____

The foregoing response to this application are true and complete. We understand that the Company will rely upon the accuracy of this application and that the Company retains the right to rescind any policy which is issued based on any application containing false or incomplete information. We understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning our professional practice. We hereby authorize the release and exchange of information involving past and future underwriting and claims matters between the Company and our past and present insurance carriers (and their agents and brokers) and we appoint the Company or attorney-in-fact to obtain such information. We hereby authorize the State Bar of California to release information to the Company concerning membership status, certified specialties, and disciplinary proceedings. We agree that any person or organization furnishing information to the Company purposed to this authorization will not be liable for the furnishing of such information.

We further agree and understand this policy shall not provide coverage with respect to any claim except and unless it is a claim by a client of the Insured and arising out of professional legal services rendered by the insured with respect to a lawsuit or other legal matter referred to the Insured by the referral service of the Bar Association(s) listed above, and such referral is made on or after the commencement of the policy period.

Signature of Applicant: _____

Print Name & Title: _____ Date: _____

Social Security or Federal Tax I.D. No.: _____

**NOTE: THIS APPLICATION WILL BE CONSIDERED ONLY IF EVERY QUESTION IS ANSWERED, THE APPLICATION IS SIGNED AND DATED.
PART II – CLAIMS INFORMATION – MUST ALSO BE SIGNED, DATED AND RETURNED EVEN IF THERE ARE NO CLAIMS.**

LAWYERS' MUTUAL INSURANCE COMPANY

Lawyers Professional Liability Insurance – Supplemental Claim Sheet

For Claims Made & Reported Policy

Please complete ONE FORM for EACH CLAIM OR INCIDENT and answer completely.

Firm Name: _____ Claim Number: _____

Claimant(s) Name: _____ Client? No Yes

Additional Defendants: _____

Lawyer(s) who rendered the legal services: _____

Lawsuit Filed? No Yes Date Filed: _____

Current STATUS of Matter: _____

Claims Reported to CARRIER? No Yes Date Reported: _____

NAME OF CARRIER: _____ POLICY LIMITS: _____

Current Reserves: _____ Defense _____ Indemnity

Amounts Paid by Carrier: _____ Defense _____ Indemnity

Amounts Paid by You: _____ Defense _____ Indemnity

CLAIM DESCRIPTION

Describe facts of representation: _____

Describe claimant's allegations: _____

Describe alleged damages: _____

Describe your defenses: _____

Describe outcome of matter: _____

Describe steps you have taken to prevent similar claims or incidents in the future: _____

NOTE: This Supplemental Claims Information Sheet does NOT require the disclosure of privileged attorney/client communications. THIS SHEET MUST BE DATED AND SIGNED BY OWNER, PARTNER OR OFFICER OF THE FIRM. FURTHER, YOU UNDERSTAND THAT THE INFORMATION SUBMITTED BECOMES A PART OF THE LAWYERS PROFESSIONAL LIABILITY INSURANCE APPLICATION AND IS SUBJECT TO THE SAME REPRESENTATIONS AND CONDITIONS.

Signature (Owner, Partner, or Officer): _____ Tax ID Number: _____

Print Name & Title: _____ Date: _____

For clarification, please CONTACT our UNDERWRITERS at - 1 (800) 252-2045