

ADMIRAL INSURANCE COMPANY

1255 Caldwell Road
Cherry Hill, NJ 08034
Phone: 856-429-9200 Fax: 856-429-8611
Internet: <http://www.admiralins.com>

**CLAIMS ADJUSTERS
SUPPLEMENT
to Miscellaneous Professional Liability Application**

1. Please complete the following sections showing the approximate percentages of your total operations involving:
- a. _____% Insurance Company Adjusting
 - b. _____% Self-Insured Adjusting
 - c. _____% Public Adjusting

2. Indicate the approximate percentages of your total revenue derived from adjusting the following lines of insurance:
- a. _____% Auto Physical Damage
 - b. _____% Auto Liability
 - c. _____% Aviation Liability
 - d. _____% Life Insurance
 - e. _____% Premises/slip & fall, etc.
 - f. _____% Products Liability
 - g. _____% Professional Liability
 - h. _____% Property (Fire & Allied Lines)
 - i. _____% Workers' Compensation
 - j. _____% Other: (describe) _____
- Total: 100 %**

3. What percentage of your adjusting services involve:
Personal Lines business? _____% Commercial Lines business? _____%

4. Does your firm provide any services to preferred provider or health maintenance organizations? Yes No
If "Yes," please provide detail by separate attachment.

5. Does your firm own or have affiliation with an insurance agency or insurance brokerage? Yes No
If "Yes," please provide the names of those agencies and/or brokerages.
- _____
- _____

- A. Does the firm, or any owner or officers of the firm own, engage in, operate, manage or act as a director or officer of any other business? Yes No **If Yes, please provide details by attachment.**

6. Do you have authority to settle on behalf of your client/carrier? Yes No
If "Yes," what is your authority limit? \$ _____

7. Do you have authority to deny claims on behalf of your client/carrier? Yes No

8. For claims handled, what is the average claim value during the past 12 months? \$ _____
Largest claim value during the past 12 months? \$ _____

9. Do you offer any services other than claims adjusting? Yes No **If Yes, please provide details by separate attachment.**

10. Please check each category where you have controls in place to guard against:
- Overpayments Underpayments Late Payments
 - Payments to incorrect plan Payments to ineligible Unfair/unjust enrichment
 - Improper refusal of benefits Failure to follow payment guidelines or procedures

11. Describe all steps to keep client information confidential:
- _____
- _____

12. Are all transactions between the adjuster, the insurance company, the insured and others carefully documented?
 Yes No If "No," please explain why not: _____
13. What is the average length of time a typical claim file remains open? _____
14. What number of files are handled per adjuster per week? _____
15. Does the Applicant utilize Structured Settlement Plans? Yes No
 If "Yes," what percentage of settlements are Structured Settlement Plans? _____%
16. List all states where you adjusted claims during the past 12 months: _____

A. List any additional states where you will be adjusting claims during the next 12 months: _____

B. Are licensing requirements met in all states where the applicant firm adjusts claims? Yes No

17. For all states where you may adjust claims, please describe the training & steps taken to ensure compliance with applicable Unfair Claims Practices Acts state laws. **Please include this on separate attachment.**
18. Within the past five years, has the firm performed any professional services for any client in which any shareholder, officer or employee of the firm had any ownership interest, or which he/she controlled, operated or managed to any extent?

Client Name	Type of Business	Ownership %	Capacity	Dates of work	% of annual revenue

19. What percentage of applicant's business involves subcontracting work to others? _____%
 Cost of subcontracted work _____ What operations are subcontracted? _____
 Are sub-contractors required to carry their own E&O insurance? Yes No
 If "Yes," what minimum limits are required of sub-contractors? _____

20. Individuals – Please list all owner(s), partners, officers, and employees engaged in professional services. Include part-time employees and all professional staff members.

Name	Title	Years of claims examining experience

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this Supplemental Information Sheet shall be in addition to the information contained in the application and will be made a part of the policy.

Date: _____

Signature: _____

Title: _____
 (Owner, Partner, Authorized Officer)

8. Is Applicant engaged in any business/profession other than as stated in question 6.? Yes [] No []
If Yes, please provide details by separate attachment.

9. Does Applicant contemplate any change in services or emphasis planned for the next 12 months?
Yes [] No [] **If Yes, please provide details by separate attachment.**

10. Please explain what type of claim or allegations could the Applicant be involved in?

11. PROFESSIONAL LIABILITY COVERAGE FOR LAST 5 YEARS (if NONE check here [])

CARRIER	LIMIT (per claim/agg)	DEDUCTIBLE	PREMIUM	EXPIRATION (mm/dd/yy)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

12. What is the **retroactive date** of expiring Professional Liability policy? _____(mm/dd/yy).

13. Has any insurer cancelled/refused to renew any similar coverage during the last 5 years? Yes [] No []
If Yes, please provide details on separate attachment .

14. Has any professional liability claim or suit been made against Applicant, any predecessor in business or against any past or present partner/officer(s)? Yes [] No [] **If Yes, please provide on separate attachment these details – allegations, amount of damages/demand, date of loss/date claim made/reserve amounts for indemnity and expenses as well as paid amounts for indemnity and expenses.**

15. Is the Applicant aware of any circumstance or incident which may result in any claim against them or any predecessor in business or any past or present partner/officer? Yes [] No []
If Yes, please provide details on separate attachment.

The Applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell no the Applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made part of the policy.

The Applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Signature of Applicant

Date

Title (Officer/Principal/Partner)