

**NLADA Insurance Program**  
**Administered by NLADA Service Corporation**

**NEW BUSINESS APPLICATION**

**Professional Liability Insurance**

**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

**INSTRUCTIONS:**

- A. Please complete the application and any supplemental applications or forms which are required.
- B. If you need more space to answer any question fully, please continue on a separate sheet of paper and indicate the questions number.
- C. All questions must be answered completely. Please type or print clearly. If any questions are considered not applicable, please explain why.
- D. Please attach a copy of the declarations page on your expiring policy.
- E. Please attach a copy of your letterhead.

**APPLICANT INFORMATION**

1. Applicant Name: \_\_\_\_\_

Year Established: \_\_\_\_\_  Sole Proprietorship  Partnership  
 Non-Profit Corporation  Other: \_\_\_\_\_

2. (a) Principal business address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(b) Telephone Number: \_\_\_\_\_ Facsimile Number: \_\_\_\_\_

(c) Other Locations?  No  Yes If yes, please list on a separate sheet.

(d) Other Entities?  No  Yes If yes, please list and explain on a separate sheet.

(e) Is Applicant a current member of NLADA?  Yes  No

(Note: *Membership in NLADA* is a requirement for participation in the NLADA Insurance Program.)

3. Please check the following category that best describes the Applicant:

- |  |  |
|--|--|
| <input type="checkbox"/> Civil Legal Services Organization | <input type="checkbox"/> Contract Defender (organization or sole pract.)           |
| <input type="checkbox"/> Public Defender Agency            | <input type="checkbox"/> Assigned Counsel (Court Appointed)                        |
| <input type="checkbox"/> Pro Bono Program                  | <input type="checkbox"/> Public Interest, Civil Rights/Liberties or Social Service |
| <input type="checkbox"/> Legal Clinic/Law School           | <input type="checkbox"/> Other (Please describe) _____                             |

4. Please describe the mission of the Applicant and its operation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Does the Applicant provide any services, other than legal?  No  Yes If yes, please describe below:  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you facilitate the provision of pro bono legal assistance for your clients by private attorneys through a Lawyer Referral Service or other special program?  No  Yes If yes, how many cases/referrals are accepted per year? \_\_\_\_\_

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7. Indicate the total number of staff by category:

Attorneys _____	Investigators/Social Workers _____
Paralegals _____	Support/Administrative Staff _____
Law Clerks/Students _____	Other (Describe) _____
Total Full-Time Staff _____	Part-Time Employees (Describe) _____

8. Do you have attorneys working for your organization who are not employees (ie. contract or volunteer attorneys)?  No  Yes If yes, please complete the following:

Attorney Name	State	Years Admitted	Hours per Month
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. List the names, states and years of admission for all attorneys: (Attach separate sheet if necessary)

Attorney Name	State	Years Admitted	FT/PT Percentage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

10. Approximate number of cases handled per staff attorney each year, if applicable: \_\_\_\_\_

11. 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?  No  Yes
12. 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?  No  Yes
13. Have all matters noted in response to Questions 11 and 12 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?  No  Yes

If the answer to questions 11, 12 or 13 was "Yes", please complete the Supplemental Claim Form.

**COVERAGE INFORMATION**

14. Expiration date of current policy: \_\_\_\_\_

15. List the professional liability insurance carried by Applicant for each of the past five years, including any interim periods during which coverage was not purchased.

Year of Coverage	Insurer	Limit	Premium
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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16. Please indicate desired limit (each claim/in the aggregate) for Lawyers Professional Liability coverage:

- \$100,000/\$300,000                       \$250,000/\$500,000                       \$500,000/\$500,000  
 \$1,000,000/\$1,000,000                       Other (Specify): \_\_\_\_\_

17. Please indicate desired deductible:

- \$1,000                       \$2,500                       \$5,000                       Other (Specify): \_\_\_\_\_

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

18. The following optional coverages are available. Please indicate the coverages for which a quote is desired:

- 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)*  
 Primary Pro Bono  
 Outside Practice of Law  
 Punitive Damages (50,000/50,000)  
 Criminal Defense (50,000/50,000)  
 Other (Please describe) \_\_\_\_\_

19. Is the Applicant required to have another entity/organization listed on your policy as an Additional Insured?  No  Yes If yes, please provide the following information for each Additional Insured required:

(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?  No  Yes

If yes, please indicate the how many days notice is required: \_\_\_\_\_

Please indicate the name and title of the individual to whom correspondence regarding this Application and/or related insurance matters should be directed.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

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:

NLADA Service Corporation, 1140 Connecticut Avenue, 9<sup>th</sup> Floor, Washington, DC 20036  
Tel: (800) 725-4513 or (202) 452-9870 Fax: (202) 452-9879

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**NEW BUSINESS APPLICATION**

**SUPPLEMENTAL APPLICATION FORM**

*This form must be completed in order to be eligible for purchase of Management Errors & Omissions or Employment Practices Liability coverages*

1. Applicant Name: \_\_\_\_\_
2. How many Directors, Officers and/or employees have resigned, been terminated or retired within the last 12 months? \_\_\_\_\_
3. (a) Does Applicant have a written human resources manual/employee handbook or equivalent written management guidelines?  No  Yes  
(b) If no such manual/handbook or guidelines exist, please describe how decisions regarding human resource issues are made: \_\_\_\_\_  
(c) Does the applicant have an internal investigation or hearing process?  No  Yes
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? If yes, please complete a Supplemental Claim Form for each incident  No  Yes
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.  No  Yes  
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?  No  Yes

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)*

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**SUPPLEMENTAL CLAIM FORM**

1. Applicant Name: \_\_\_\_\_
2. Name(s) of the attorneys involved in the claim or incident: \_\_\_\_\_
3. Name(s) of potential/actual claimant(s): \_\_\_\_\_
4. Indicate whether     incident             claim             lawsuit             disciplinary complaint/action
5. Date of alleged act, error or omission: \_\_\_\_\_
6. Date claim or incident reported to Applicant's insurer: \_\_\_\_\_  
Name of Insurer: \_\_\_\_\_
7. If closed, total amount paid, including settlements, judgments, loss and defense costs: \_\_\_\_\_  
Was this amount paid for:  judgement     arbitration award     settlement     defense costs.
8. Current status of the claim or incident:     open             closed
9. Description of claim or incident (attach appropriate documentation): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

Applicant understands that the information submitted herein becomes a part of the professional liability insurance application and is subject to the same representations and conditions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

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