The Hanover Insurance Group™

HANOVER

Miscellaneous Advantage

Professional Liability Insurance

Small Firm New Business Questionnaire

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Underwritten by The Hanover Insurance Company

NOTICE: THIS QUESTIONNAIRE IS FOR A CLAIMS-MADE AND REPORTED POLICY. SUBJECT TO ITS TERMS, THIS POLICY WILL APPLY ONLY TO CLAIMS FIRST MADE AGAINST THE INSUREDS AND REPORTED TO THE INSURER DURING THE POLICY PERIOD OR ANY EXTENDED REPORTING PERIOD THAT MAY APPLY. PLEASE READ THE POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, COVERAGE AND COVERAGE RESTRICTIONS.

INSTRUCTIONS

Whenever used in this Questionnaire, the term **Applicant** shall mean the **Named Insured** proposed for insurance, and **You** or **Your(s)** shall mean the persons and entities, subsidiaries, proposed for insurance unless otherwise stated.

A. CONTACT INFORMATION

1. Full Legal Name of **Applicant** (include all firm names, franchise affiliations, trading names and DBAs under which the **Applican**t operates): _____

   Applicant is a: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ LLC ☐ LLP

   ☐ Independent Contractor ☐ Other: _____

2. Mailing and Physical Address of **Applicant** including contact information:

   Mailing Address: _____

   City: _____ State: _____ Zip Code: _____

   Physical Address (if different): _____

B. GENERAL BUSINESS INFORMATION

3. A) Date **Applicant** was established: _____ B) How many years of industry experience do **You** have? ____

4. Describe **Your** Professional Services: _____

   _____

   _____

5. Total revenue the past 12 months: _____ Total revenue projected next 12 months: _____

6. Please complete the following information for the current year:

Staff	Full Time	Part Time
Principals/Professionals		
Administrative/Clerical		

7. Does the **Applicant** have any subsidiaries for which coverage is requested? Yes ☐ No ☐

   If "Yes", please complete the Subsidiary Information schedule below.

Full Legal Name	% Owned	Year Started	Description of Operations

IMPORTANT: It is understood and agreed that coverage is not provided for subsidiaries not fully disclosed in response to Question 7.

8. Are **Your** computer systems protected with regularly updated firewall, anti-virus and anti-malware software? ☐ Yes ☐ No
9. Are **Your** portable electronic devices and removable electronic media protected by encryption? ☐ Yes ☐ No
10. Do **You** require annual training on information security for all personnel? ☐ Yes ☐ No

C. CURRENT INSURANCE INFORMATION

11. Please provide the following information regarding the **Applicant's** most recent insurance policy. If no coverage is currently in-force please indicate with a N/A.

Insurance Carrier		*Expiration Date*	*Limit of Liability*	*Deductible*	*Premium*
			$ /$	$	$
Retroactive Date:		*(This is the date the Applicant first purchased claims made coverage that has been continuously in-force without interruption.)*			

12. During the past 5 years, has any professional liability claim or suit ever been made against the **Applicant**, any predecessor firm or any of the **Applicant's** current or former professional staff? ☐ Yes ☐ No

    If "Yes", please indicate how many:_____Please submit 5-year loss runs and complete a Supplemental Claim Form for each claim.

13. Does any of the **Applicant's** professional staff know of any incident, negligent act, error or omission, or other circumstance that could result in a claim or suit against the **Applicant** or any predecessor firm or any of the **Applicant's** current or former professional staff? ☐ Yes ☐ No

    If "Yes", indicate how many:_____and complete a Supplemental Claim Form for each potential claim.

14. Has any of the **Applicant's** or a predecessor firm's professional staff ever had their license revoked or suspended or been formerly reprimanded or been the subject of a disciplinary action? ☐ Yes ☐ No

    If "Yes", please provide complete details on a separate sheet.

The undersigned, acting on behalf of all Applicants, declares that the statements above are true and complete, that thorough efforts were made to obtain requested information from all persons to be insured, no facts have been suppressed or misstated, and I/we understand that this supplement becomes part of the questionnaire.

Date **Signature / Title**

_____ _____
(mm/dd/yyyy) (Chief Executive Officer, President, Financial Officer, Managing Partner or Owner)

_____ _____
(mm/dd/yyyy) (Print Name and Title)

A POLICY CANNOT BE ISSUED UNLESS THE "QUESTIONNAIRE" IS PROPERLY SIGNED AND DATED.
Please submit this "Questionnaire" including appropriate documentation to your agent.