## Actuary Application

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| General Information | | | | | | | | | | | | | | | | | | |
| 1. Name of Applicant | | | | |  | | | | | | | | | | | | | |
| Address: | | | | |  | | | | | | | | | | | |  | |
|  | | | Street | | | | | | | | City/State | | | | | | Zip Code | |
| Other Applicants (explain relationship) | | | | | | | | |  | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | |
| Other locations: | | | | |  | | | | | | | | | | | | | |
| Applicant’s Web site: | | | | | |  | | | | | | | | Telephone #: | | | | |
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| 1. Applicant is:  Individual  Partnership  Corporation  LLC  Non-Profit Organization | | | | | | | | | | | | | | | | | | |
|  | Other: | | | | | | | | | | | | | | | | | |
| 1. Date Firm Established (MM/DD/YYYY) | | | | | | | | | | | | | | | | | | |
| 1. Has the name of the firm ever changed? Have there ever been any acquisitions, consolidations, dissolution or merger?   Yes  No If Yes, please explain: | | | | | | | | | | | | | | | | | | |
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| 1. Is the firm engaged in, owned by, associated with or controlled by any other business?  Yes  No   If Yes, please explain: | | | | | | | | | | | | | | | | | | |
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| PROFESSIONAL SERVICES AND SPECIALTY (Attach Narrative description if necessary) | | | | | | | | | | | | | | | | | | |
| 1. A. Describe in detail the professional services (life, pension, casualty, or health) for which coverage is desired and indicate the % of gross receipts/revenue derived from each activity: | | | | | | | | | | | | | | | | | | |
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| B. Gross Annual Receipts/Revenue: | | | | | | | | | Next Year | | | |  | | | | | |
|  | | | | | | | | | This Year | | | |  | | | | | |
|  | | | | | | | | | Last Year | | | |  | | | | | |
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| 1. Please include by attachment to this application: 2. Five largest clients and description of services performed for each include revenue 3. Resume for all professionals 4. Association/memberships, licenses or certifications, brochures/advertisements 5. Sample of standard contract used 6. Most current financial data (annual report or balance sheet) 7. Loss runs for previous carriers for the last 3 years 8. Copy of current policy declaration page showing retro date | | | | | | | | | | | | | | | | | | |
| 7. Total Number of Employees | | | | | | |  | | |  | | | | | | | | |
| Partners/Officers: | | | | | | |  | | | Administrative/Clerical: | | | | |  | | | |
| Professional/Technical: | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Sub-Contractors: \_\_\_\_\_\_\_ | | | | |  | | | |
| 1. Is Applicant engaged in any business/profession other than as stated in question 6?  Yes  No   If Yes, please explain: | | | | | | | | | | | | | | | | | | |
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| 1. Does Applicant contemplate any changes in services or emphasis planned for the next 12 months? Yes  No   If Yes, please explain: | | | | | | | | | | | | | | | | | | |
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| 1. PROFESSIONAL LIABILITY COVERAGE FOR THE PAST 5 YEARS (If None, check here  ) | | | | | | | | | | | | | | | | | |
| **Carrier** | | | | **Limit**  **(Per Claim/Agg.)** | | | | **Deductible** | | | | **Expiration** | | | | **Premium** | |
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| 1. What is the retroactive date of the expiring Professional Liability Policy? (MM/DD/YYYY) | | | | | | | | | | | | | | | |  | |
| 1. 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 | | | | | | | | | | | | | | | | | |
| 1. Has any professional liability claim or suit been made against Applicant, any predecessor in business or against any past or present partner/officer (s) in the last 5 years?  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. | | | | | | | | | | | | | | | | | |
| 1. 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 additional details on separate attachment. | | | | | | | | | | | | | | | | | |

## Actuary Supplemental Application

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| General Information | | | | | | | | | | | |
| Total Number of Actuaries or Other Professionals | | | | | |  | | | | | |
| Type of Clients: | | | | | | | | | | | |
| Insurance Companies |  | | % |  | Local Government | | |  | | % | |
| Unions |  | | % |  | Consulting\* | | |  | | % | |
| Federal Government |  | | % |  | Other  (Describe Below) | | |  | | % | |
| State Government |  | | % |  |  | | | | | | |
|  | | | | | Total (Must be 100%) | | | |  | | |
| \* If consulting clients, provide a narrative description of the work performed and copy of standard contract. | | | | | | | | | | | |
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| If any “Insurance Company” work, please answer question below: | | | | | | | | | | | |
| How many carriers have been downgraded or gone into receivership or bankruptcy during the past 25 months? | | | | | | |  | | | | |
| What portion of actuarial or consulting gross revenues are from the following areas: | | | | | | | | | | | |
| Property & Casualty |  | % | |  | Pension | | |  | | % | |
| Life |  | % | |  | Other (Describe) | | |  | | % | |
| Health |  | % | |  |  | | | | | | |
|  | | | | | | | | | | | |
| Does the Applicant consult on mergers and acquisitions  Yes  No If Yes, Please complete below: | | | | | | | | | | | |
| 1. How many such consultations (even if merger/acquisition is not completed) in the past 24 months? | | | | | | | | | | |  |
| 1. How many consultations are projected in the next 12 months? | | | | | | | | | | |  |
| 1. Please complete the following exhibit for all merger/acquisition work for the past 24 months: | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Date Work Performed** | **Industry** | **Description of Work** | **Capitalization or Revenue Size of Company** | **Publicly or Privately Held** | **Gross Revenue for Work Performed** | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | | | | | | | | | | | | |

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| How many actuaries with the firm hold the following designations? | | | | | |
| FCAS |  |  | FSA |  | |
| ACAS |  |  | ASA |  | |
| FSPA |  |  | MSPA |  | |
| After inquiry with each person as appropriate, in the last five years, has any professional liability claim or suit ever been made against the firm or any predecessor firm or any current or former member of the firm or predecessor firm?  Yes  No If Yes, How Many?  **Please include separately each claim or suit and include a currently valued loss run for each claim or suit.** | | | | | |
| After inquiry with each person as appropriate, do you or any of your partners, officers, directors, or employees know of any circumstances, acts, errors or omissions or any allegations or contentions of any incident that could result in a claim?  Yes  No If Yes, How Many?  **Please include separately each claim or suit and include a currently valued loss run for each claim or suit.** | | | | |
| After inquiry with each person as appropriate, has any current or former actuary or other professional for who coverage is sought ever been sanctioned by an administrative agency or regulatory body, including Actuarial Board for Consulting and Discipline, or been subject of a disciplinary complain made to any of the aforementioned entities?  Yes  No  **If Yes, please provide a copy of the complaint, your response and a copy of the decision.** | | | | | |

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 FORM AC-0081 AND WILL BE MADE PART OF THE POLICY.

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| Signature of Applicant |  | Date |
|  |  |  |
| Title (Officer/Principal/Partner) |

**PLEASE RETURN YOUR COMPLETED APPLICATIONS TO:**

**Rich Brew, CPUC, AAI, Vice President**

**Email: rich.brew@hubinternational.com**

**Nita Butler, ACSR, Account Manager**

**Email:** [**nita.butler@hubinternational.com**](mailto:nita.butler@hubinternational.com)

**10739 Deerwood Park Boulevard, Suite 200C:\Program Files (x86)\Microsoft Office\MEDIA\OFFICE14\Bullets\BD21435_.gifJacksonville, FL 32256**

**(904) 398-1234 C:\Program Files (x86)\Microsoft Office\MEDIA\OFFICE14\Bullets\BD21435_.gifFax (904) 396-7432C:\Program Files (x86)\Microsoft Office\MEDIA\OFFICE14\Bullets\BD21435_.gif www.hubinternational.com**