

- ACE American Insurance Company
- Illinois Union Insurance Company
- Westchester Fire Insurance Company
- Westchester Surplus Lines Insurance Company

**INSTRUCTIONS**

Please type or print all answers clearly. Answer all questions completely, leaving no blanks. If there is insufficient space to complete an answer, please continue on a separate sheet indicating the question number. If any questions, or any part thereof, do not apply, print N/A in the space. This Application must be completed, signed, and dated by an authorized officer of your firm. Underwriters will rely on all statements made in this application.

The Policy for which you are applying is written on a claims-made and reported basis; only claims first made against the Insured and reported to the Company during the Policy Period are covered subject to the Policy Provisions.

The Limits of Liability stated in the Policy are reduced, and may be exhausted, by Claims Expenses. Claims Expenses are also applied against your Retention, if any. If you have any questions about coverage, please discuss them with your insurance agent.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

1. Name of Applicant/Named Insured: _____	
2. Name of Plaintiff: _____	
3. Date of Claim: _____	4. Date of alleged act or omission: _____
5. Professional Services Rendered: _____	
6. Status:	
<input type="checkbox"/> Claim	<input type="checkbox"/> Open
<input type="checkbox"/> Suit	<input type="checkbox"/> Closed
	<input type="checkbox"/> Reported to Insurer
	<input type="checkbox"/> Not reported to Insurer
7. If closed:	8. If open:
Date closed: _____	_____ Insurers Loss Reserve
Total paid: \$_____ damages	_____ Insurers Expense Reserve
\$_____ defense costs	_____ Defense Costs paid to date
\$_____ deductible	
9. Insurer: _____	
10. Description of Claim or Circumstance: _____	

\_\_\_\_\_  
Signature of Application or Authorized Representative of Insured

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Title

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date (Mo./Day/Yr.)