



**LAWYERS PROFESSIONAL LIABILITY INSURANCE**

**LOW INCOME LAWYER PROGRAM (LILP) APPLICATION**

**Claims Made & Reported Policy**

Please complete this form to the best of your knowledge and return with a *sample of the Firm's Letterhead*

**I. General Information:**

Full Name of Applicant: \_\_\_\_\_ Law School: \_\_\_\_\_  
Degree/Year: \_\_\_\_\_ State Bar Number: \_\_\_\_\_  
Date of Admission: \_\_\_\_\_ Primary Address: \_\_\_\_\_  
Primary Contact Number: \_\_\_\_\_ Primary Fax Number: \_\_\_\_\_  
Primary Contact Email: \_\_\_\_\_ Website Address: \_\_\_\_\_  
Date the Firm was Established: \_\_\_\_\_ Effective Date Requested: \_\_\_\_\_  
Applicant Lawyer is an: Individual / Corporation / Other (Explain) \_\_\_\_\_  
Applicant Lawyer is a Solo Practitioner: Yes / No (Explain) \_\_\_\_\_

**Note:** "Solo practitioner" means that you or your professional corporation do not employ any other lawyers, and do not have a partner, a professional association or any similar arrangements. You can act as an "Of Counsel" or act as an Independent Contractor for another lawyer or law firm (subject to underwriting criteria).

**II. Firm - Area of Practice:**

Please indicate the top 3 Areas of Law and the percentage practiced based upon Applicant Lawyer's caseload for the last three years or if less than three years, the amount of time that Applicant Lawyer has most recently been a solo practitioner. If this is a new practice, indicate anticipated Areas and percentages.

1. Area of Practice: \_\_\_\_\_ Percentage: \_\_\_\_\_  
2. Area of Practice: \_\_\_\_\_ Percentage: \_\_\_\_\_  
3. Area of Practice: \_\_\_\_\_ Percentage: \_\_\_\_\_

**Note:** If ANY percentage of your practice does or will include class action, copyrights, patents, trademarks, intellectual property, entertainment, environmental, investment counseling/money management, personal injury, municipal land, public utilities, real property, securities, tax or estate planning, then (on a separate sheet) please specify the Area of Law, percentage, type of client and describe the legal services to be performed.

**IMPORTANT:** This is an application for a **Claims-Made and Reported Policy**. The Policy issued by Lawyers' Mutual Insurance Company EXCLUDES coverage for your prior acts. This means that the Company will not defend or indemnify you for any claim arising out of an act, error or omission which occurred prior to the Policy effective date.

**III. Limits and Deductible:**

Upon approval of this LILP Application, the Limits of Liability for the LILP policy will be \$100,000 each claim/\$100,000 annual aggregate with a \$250 per claim deductible. No additional limit or deductible options will be available.

**IV. Claim Experience and Professional Standing:**

- 1. Has the Applicant Lawyer ever withdrawn or had declined an application for any professional liability policy, or ever had any such policy non-renewed, cancelled, rescinded or had coverage restricted?  Yes  No
- 2. Does the Applicant Lawyer have knowledge of or reason to suspect any act, error, omission or any disagreement with any former or current client, employer or third party or dissatisfaction with services rendered or fees charged, which might reasonably give rise to a claim or suit against the Applicant Lawyer?  Yes  No
- 3. Has the Applicant Lawyer ever had any claim made against him or her alleging any liability arising from the performance of professional services?  Yes  No
- 4. Has the Applicant Lawyer ever had or defended a claim against him or her and not reported it to an insurance carrier?  Yes  No
- 5. Has the Applicant Lawyer sued for fees during the past 3 years?  Yes  No
- 6. Has any disciplinary proceeding (including but not limited to reprimand, reproval, probation, suspension or disbarment) ever been brought by the State Bar of California, or any other State Bar, against the Applicant Lawyer?  Yes  No
- 7. Has the Applicant Lawyer ever been refused admission to practice before any court or administrative agency?  Yes  No
- 8. Has the Applicant Lawyer ever been charged or convicted of any state or federal offense?  Yes  No

**IMPORTANT:** This Policy **WILL NOT PROVIDE COVERAGE** for any actual or potential **CLAIMS KNOWN** to any applicant/insured **PRIOR TO THE INCEPTION OF THIS POLICY**, including matters disclosed on this application. Any such claims should be reported to your current carrier prior to expiration of your current Policy.

**V. Income and Insurance:**

- 9. What was the Applicant Lawyer's gross revenue from legal services for each of the last three years?  
Year 1) \_\_\_\_\_ Year 2) \_\_\_\_\_ Year 3) \_\_\_\_\_
- 10. Has the Applicant Lawyer been covered by professional responsibility insurance for his/her legal services as a solo practitioner in the past one year? If yes, prior acts coverage will not be offered to new applicants.  Yes  No

**VI. Firm Management:**

- 11. Does Applicant Lawyer have a system for cross-referencing his/her own client list in order to prevent potential conflicts of interest?  
Explain: \_\_\_\_\_  
\_\_\_\_\_
- 12. Check which of the following calendaring systems Applicant Lawyer utilizes. Provide specific details for each:

	<b>Check</b>	<b>Description</b>
a. Lawyer calendar	_____	_____
b. Matching secretary calendar	_____	_____
c. Computerized system	_____	_____
d. Other (explain):	_____	
- 13. Describe how the calendars checked in Question 12.a and Applicant Lawyer's internal office procedures are coordinated to notify him/her of scheduled matters on these calendars.  
\_\_\_\_\_

**VII. Disclosure:**

**IMPORTANT NOTE**

The forgoing responses are true and complete. Applicant understands that the Company will rely upon the accuracy of this application and that the Company retains the right to rescind any Policy which is issued based upon an application containing false or incomplete information. Applicant hereby authorizes the release and exchange of information involving underwriting and claims matters between the Company and our past and present carriers and appoints the Company our attorney-in-fact for obtaining such information. Applicant hereby authorizes the State Bar of California to release information to the Company concerning membership, certifications and disciplinary proceedings. Applicant agrees any person or organization furnishing information to the Company pursuant to this authorization will not be liable for furnishing such information, even if the information is inaccurate or untrue.

THIS APPLICATION WILL BE CONSIDERED ONLY IF ALL QUESTIONS ARE ANSWERED, LETTERHEAD IS ATTACHED, AND THE APPLICATION IS SIGNED AND DATED BY AN OWNER, PARTNER OR OFFICER OF THE APPLICANT FIRM. APPLICANT MUST REPORT ANY CHANGES IN THESE ANSWERS OF WHICH IT BECOMES AWARE AFTER SIGNING THIS APPLICATION BUT BEFORE THE EFFECTIVE DATE OF THE POLICY. IF APPLICANT BECOMES AWARE OF ANY ACTUAL OR POTENTIAL CLAIM AFTER SIGNING THIS APPLICATION AND BEFORE THE EFFECTIVE DATE OF THE POLICY, SUCH ACTUAL OR POTENTIAL CLAIM WILL NOT BE COVERED UNDER THIS POLICY.

**VIII. Warranty & Signature:**

**YOU UNDERSTAND AND AGREE THAT, BY SIGNING THIS APPLICATION, YOU WARRANT THAT ALL ANSWERS HEREIN, INCLUDING THOSE IN SECTION V REGARDING INCOME FROM PROFESSIONAL SERVICES, ARE TRUE AND CORRECT, AND YOU ACKNOWLEDGE THAT THE PROPOSED INSURANCE, IF ISSUED, WILL BE ISSUED IN RELIANCE ON THIS WARRANTY.**

Signature (Owner, Partner, or Officer): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name & Title: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred Method of Contact (please select one):  Email  USPS

**For clarification, please CONTACT our UNDERWRITERS at - 1 (800) 252-2045**

LAWYERS' MUTUAL INSURANCE COMPANY

Lawyers Professional Liability Insurance – Supplemental Claim Sheet

For Claims Made & Reported Policy

Please complete ONE FORM for EACH CLAIM OR INCIDENT and answer completely.

Firm Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Claimant(s) Name: \_\_\_\_\_

Client?  No  Yes

Additional Defendants: \_\_\_\_\_

Lawyer(s) who rendered the legal services: \_\_\_\_\_

Lawsuit Filed?  No  Yes

Date Filed: \_\_\_\_\_

Current STATUS of Matter: \_\_\_\_\_

Claims Reported to CARRIER?  No  Yes

Date Reported: \_\_\_\_\_

NAME OF CARRIER: \_\_\_\_\_

POLICY LIMITS: \_\_\_\_\_

Current Reserves: \_\_\_\_\_ Defense

\_\_\_\_\_ Indemnity

Amounts Paid by Carrier: \_\_\_\_\_ Defense

\_\_\_\_\_ Indemnity

Amounts Paid by You: \_\_\_\_\_ Defense

\_\_\_\_\_ Indemnity

CLAIM DESCRIPTION

Describe facts of representation: \_\_\_\_\_

Describe claimant's allegations: \_\_\_\_\_

Describe alleged damages: \_\_\_\_\_

Describe your defenses: \_\_\_\_\_

Describe outcome of matter: \_\_\_\_\_

Describe steps you have taken to prevent similar claims or incidents in the future: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NOTE: This Supplemental Claims Information Sheet does NOT require the disclosure of privileged attorney/client communications. THIS SHEET MUST BE DATED AND SIGNED BY OWNER, PARTNER OR OFFICER OF THE FIRM. FURTHER, YOU UNDERSTAND THAT THE INFORMATION SUBMITTED BECOMES A PART OF THE LAWYERS PROFESSIONAL LIABILITY INSURANCE APPLICATION AND IS SUBJECT TO THE SAME REPRESENTATIONS AND CONDITIONS.**

Signature (Owner, Partner, or Officer): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name & Title: \_\_\_\_\_ Date: \_\_\_\_\_

**For clarification, please CONTACT our UNDERWRITERS at - 1 (800) 252-2045**