LAWYERS' MUTUAL INSURANCE COMPANY

LAWYERS PROFESSIONAL LIABILTIY 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 anyprofessional 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 foreach:

	Check	Description
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

Completed applications should be returned via email to applications@lawyersmutual.com, or via fax to (818) 565-5516 or via mail to 3110 W. Empire Ave., Burbank, CA 91504.

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