



HOME INSPECTORS
PROFESSIONAL LIABILITY
INSURANCE APPLICATION

Return Applications to:
Fox Point Programs, Inc.
3001 Philadelphia Pike Claymont, DE 19703
Phone: 800-499-7242 • Fax: 302-765-2088
www.foxpointprg.com
E-mail: submissions@foxpointprg.com

FOR THE MOST RECENT VERSION OF THIS APPLICATION, PLEASE VISIT WWW.FOXPOINTPRG.COM

NOTICE: 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.

1 GENERAL INFORMATION

a Applicant Name: (as it should appear on the policy; name should match current policy information, unless endorsed otherwise)
d/b/a:
b Physical Address:
City: State: ZIP:
c Contact Name: Email:
Phone: () Fax: () Website:
d Business Type: Corporation Partnership LLC Other:
e Year Established: Number of Active Inspectors: Total Number of Employees:

2 BUSINESS PRACTICES & HISTORY

a How many years of related professional experience does the principal or other key professional employee have? Years
b What percentage of work is performed inspecting commercial, industrial or office locations? %
c What percentage of work is performed involving homes valued at \$1,000,000 and higher? %
d What percentage of work is performed involving compliance inspections (codes, regulations, laws, etc.)? %
e What percentage of your customers sign either a written contract or agreement for services? %
f What percentage of your contracts are reviewed by your legal department or a third party law firm? %
g Does this Applicant have any Subsidiaries? Yes No
h Does more than 50% of your revenue come from a single client? Yes No
i Is the Applicant owned, controlled or affiliated with any other entity? Yes No
j Has the name of the Applicant ever been changed? Yes No
k Has the Applicant ever been the subject of any merger, acquisition or consolidation? Yes No
l Do you anticipate any material changes to the nature of the Applicant's business in the next 12 months, including but not limited to substantial increase in or reduction of staffing (net change of +/- 10% or more), any change in business strategy, structure or plan, or any other material change in business? Yes No

If the answer is "Yes" to questions 2g- 2l, please explain on a separate sheet (attached).

3 CLAIMS HISTORY

- a** After inquiry, do any principals, directors, officers, partners, professional employees or independent contractors of the Applicant have knowledge or information of any actual or alleged acts, errors, omissions, offenses or circumstances which might reasonably be expected to give rise to a claim against the Applicant or any proposed insured entity? Yes No
- b** During the past five years, has the Applicant, or any of its predecessors in business, subsidiaries or affiliates, or any of the principals, directors, officers, partners, professional employees or independent contractors ever been the subject of a disciplinary action as a result of professional activities? Yes No
- c** During the past five years, have any claims or suits been made against the Applicant, any predecessors in business, subsidiaries, affiliates or any principal, director, officer or professional employee? Yes No
- d** Has the Applicant reported the matters listed in the above 3 questions to its current or former insurance carrier? Yes No N/A

4 REVENUE

a Please complete the items in the below chart, where applicable:

	YEAR	REVENUES	% NON U.S. REVENUES
Prior Fiscal Year		\$	%
Current Fiscal Year		\$	%
Projected Next Fiscal Year		\$	%

5 CURRENT/PRIOR INSURANCE

a Does the Applicant currently have an Errors & Omissions Insurance policy? Yes No

If "Yes," please attach a current Policy Declarations Page (plus any endorsements applied). Please be sure we can recognize both the Expiration Date and the Retroactive Date.

Please provide the following information for any Errors & Omissions or Professional Liability Insurance during the last 3 years:

COMPANY (PLEASE ENTER FULL NAME OF CARRIER)	LIMIT OF LIABILITY (PER CLAIM/AGGREGATE)	DEDUCTIBLE	PREMIUM	POLICY PERIOD (EFF DATE - EXP DATE)	RETRO DATE (MM/DD/YYYY)
		\$	\$		
		\$	\$		
		\$	\$		

b Has any Errors & Omissions or Professional Liability Insurance issued to the Applicant ever been declined, cancelled or non-renewed? Yes No

If "Yes," please explain on the separate sheet provided.

6 LIMIT/DEDUCTIBLE OPTIONS

(a) LIMIT OPTIONS (b) DEDUCTIBLE OPTIONS

Select:	..... \$100,000 / \$100,000	..... \$ 1,000
(a) Limit Options and	..... \$100,000 / \$300,000	..... \$ 1,500
(b) Deductible Options Desired	..... \$250,000 / \$250,000	..... \$ 2,500
Some restrictions may apply based on underwriting criteria.	..... \$250,000 / \$500,000	..... \$ 5,000
	..... \$500,000 / \$500,000	..... \$ 10,000
	... \$500,000 / \$1,000,000	..... \$ 15,000*
* Requires \$250,000 / \$500,000 Minimum Limits	.. \$1,000,000 / \$1,000,000	..... \$ 25,000*

7 ADDITIONAL COVERAGES

**(a)
RADON/TERMITE COVERAGE**

**(b)
GENERAL LIABILITY COVERAGE***

Select: (a) Radon/Termite Option and (b) General Liability Option Desired Some restrictions may apply based on underwriting criteria.	..... Radon Coverage	..... \$100,000/\$100,000
	..... Termite Coverage	..... \$100,000/\$500,000
		..... \$150,000/\$500,000
		..... \$250,000/\$250,000
	..... None	..... \$300,000/\$300,000
		..... \$500,000/\$500,000
		*GL Coverage requires completion/acceptance of the GL Supplemental Application

8 ASSOCIATIONS

a Are you currently a member of any home inspector associations? Yes No

If "Yes," please list: _____

I/We hereby warrant that the statements and particulars provided in this Application are true and that I/we have not suppressed or misstated any material facts and that I/we agree that this Application shall be the basis of the contract with the Company and that the coverage, if written, may be affected by any suppression or misstatement. It is understood and agreed that this Application forms a part of any Policy issued by the Company to the Applicant and shall be deemed to be attached to and form a part of the Policy. It is understood and agreed that completion of this Application does not bind the Company to issue nor the Applicant to purchase the insurance.

Applicant Signature: _____ Date: ____/____/____
(MUST be signed by an Owner, Partner, Director or Officer of the Named Insured. It is agreed the signer has authority to act on behalf of all insureds.)
MM DD YYYY

Print Name _____ Print Title _____

PRODUCER SUBMITTING ON BEHALF OF THE INSURED

Agency Name: _____	License #: _____
Agent Name: _____	Phone #: (____) _____
Address: _____	
City: _____	State: _____ ZIP: _____
E-mail Address: _____	
Do you authorize Fox Point Programs to broker this account if not eligible for our in-house program? Yes No	

**Fox Point
Programs**



SUPPLEMENTAL CLAIM QUESTIONNAIRE

THIS SUPPLEMENTAL FORM IS TO BE COMPLETED BY THOSE APPLICANTS WHO HAVE EITHER 1) BEEN THE SUBJECT OF A PROFESSIONAL LIABILITY CLAIM, OVER THE PAST TEN (10) YEARS, OR 2) ARE AWARE OF A SITUATION THAT MAY GIVE RISE TO A CLAIM IN THE FUTURE. PLEASE BE SURE TO ANSWER ALL QUESTIONS. FAILURE TO DO SO MAY DELAY PROCESSING OR RESULT IN THE SUBMISSION'S DECLINATION.

COMPLETE ONE SUPPLEMENTAL APPLICATION FOR EACH CLAIM OR INCIDENT.

a Applicant Name: _____

b Name of the Claimant(s) or potential Claimant(s): _____

Date of the alleged act, error, or omission: _____

Is this a: Claim Lawsuit Administrative/Disciplinary Hearing Incident (potential claim)

Is this matter settled? Yes No *If "Yes," what was the final disposition (monetary award, administrative sanction, etc.?)*

What was the total indemnity amount paid? \$ _____

What were the total defense/legal costs paid? \$ _____

If the matter is still pending, what remedy is being sought by the Claimant(s): _____

c Provide a brief description incident being reported: _____

d Please describe procedures instituted to avoid like claims: _____

e Was the Applicant insured under a Professional Liability policy at the time of the incident? Yes No

If "Yes", provide the insurance company name and policy number:

THE APPLICANT WARRANTS THAT THE STATEMENTS AND RESPONSES TO THE QUESTIONS ON THIS APPLICATION ARE TRUE AND COMPLETE. THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY, NOR DOES IT OBLIGATE THE COMPANY TO ISSUE A POLICY. SUCH POLICY MAY BE CANCELLED BY THE COMPANY FROM INCEPTION UPON DISCOVERY THAT THE POLICY WAS OBTAINED THROUGH A FRAUDULENT STATEMENT, OMISSION, OR CONCEALMENT OF THE FACTS MATERIAL TO THE ACCEPTANCE OF THE RISK OR HAZARD ASSUMED.

Date

Applicant's Authorized Signature



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GENERAL LIABILITY INSURANCE *SUPPLEMENTAL APPLICATION*

THIS SUPPLEMENTAL FORM IS TO BE COMPLETED BY THOSE APPLICANTS SEEKING GENERAL LIABILITY COVERAGE IN ADDITION TO PROFESSIONAL LIABILITY INSURANCE. PLEASE BE SURE TO ANSWER ALL QUESTIONS. FAILURE TO DO SO MAY DELAY PROCESSING OR RESULT IN THE SUBMISSION'S DECLINATION.

A Name of Applicant _____

Business Address _____

City _____ State _____ Zip _____

B Please provide a brief description of the services provided by the Applicant: _____

C What limits of liability are being sought? _____ Desired effective date ____ / ____ / ____

D Is the Applicant's business operated out of his/her home? Yes No

E Other than the business address provided in "A" above, now many additional locations does the Applicant's business own or rent?

F What best describes the Applicant's ownership structure? Sole Proprietor Partnership Corporation

Other (*describe*): _____

G How many staff are currently employed? Full-time _____ Part-time _____ Temporary _____ TOTAL _____

H Does the Applicant supply, manufacture, or distribute tangible goods or products (NOTE: brochures, documents, and reports are not considered tangible goods)? Yes No

If "Yes", are the products provided limited to those manufactured by others and do the total sales from these products account for no more than 25% of the Applicant's annual revenues? Yes No

I Does the Applicant currently have a general liability policy in-force? If yes, please provide the following:

COMPANY		LIMITS	DEDUCTIBLE	PREMIUM
		\$	\$	\$
EXPIRATION DATE	RETRO DATE			
/ /	/ /			

J Has any prior General Liability insurance policies been cancelled or non-renewed? Yes No

K Has the Applicant had any General Liability claims in the past five years, or have knowledge/information of any circumstance which might reasonably be expected to give rise to a claim? Yes No

L For the next 12 months, what is your estimated payroll expense for the Applicant and its employees (do not include sub-contractors)? \$ _____

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Date ____ / ____ / ____ Applicant's Authorized Signature _____