



## Professional Liability Insurance Application for Nondestructive Testing Consultants

### Questions?

Contact: Barry Peters  
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Alliant Insurance Services, Inc.  
4530 Walney Road  
Suite 200  
Chantilly, VA 20151

### Section 1: Applicant

Contact Name: \_\_\_\_\_ Email: \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Business Telephone: \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Cell no: \_\_\_\_\_ Fax No: \_\_\_\_\_  
Are you and your employees members of ASNT? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list all of the staff (including partners/officers/principles), listing their job roll and their ASNT Certification levels.

List related trade organization memberships:

Please provide ASNT member number:

### Section 2: Company Background

- a) Indicate firm type: Corporation Partnership  
Sole Proprietorship Joint Venture
- b) If an individual, are you: Full Time Part Time (Moonlighting – if part time, must be employed elsewhere fulltime)
- c) Does the Applicant have:  
 Subsidiaries  Parent Company Other Related or Affiliated Entities

If yes please describe \_\_\_\_\_

d) Periods for financial year end. Revenue figures must be provided in order to provide a quote. If you do not have a full year of gross revenues please provide revenue projection for a complete 12 month fiscal year. Please note carrier may request to review annual revenue statements.

Gross billings, sales, fees, and commissions

Previous 12 Months	Current 12 Months	Next 12 Months

- e) Please list below the services provided, the corresponding percentage of annual gross revenue and the subcontracted revenue:  
(if you are not yet in business, please give an estimate of your anticipated breakdown after the first year in business)

**Services**

i) Please describe areas of Testing Services below stating the % of income derived from each service and a description of each.

a. %

b. %

c. %

d. %

**Total** (should be 100%) %

\*Please include any additional information below:

Yes    No

f) Do you utilise Subcontractors/Independent Contractor?

g) Are certificates of insurance required from these Subcontractors/ Independent Contractor?

h) If yes, what are the minimum requirements?                      General Liability \$ \_\_\_\_\_

Professional Liability \$ \_\_\_\_\_

Yes    No

i) Are subcontractors/ Independent Contractor hired under written contract?

j) If yes, do contracts contain hold Harmless or indemnification provisions in favour of the Applicant?

k) Staff:

**Total staff, personnel of Applicant**

Partners/Officers/Principals

Technical

Clerical

Total

### Section 3: Operations

a) Briefly describe your largest job during the past three years: (if you're not yet in business please enter 0.)

Contract Value: \_\_\_\_\_ Scope of Work:

**NOTE: If you are not yet in business, please answer as if you were in business:**

Yes No

- a) Are written contracts or agreements always used in describing the services the Applicant will provide?
- b) If microbial work is performed, do contracts contain specific limitations, protections or disclaimers related to this type of work?
- c) Do all contracts contain hold harmless or indemnity agreements to the Applicant's benefit?

### Section 4: Coverage

a) Please provide prior carrier information for the last three (3) years:

i) Professional Liability:

Expiration Date	Carrier	Policy #	Limits	Deductible	Total Premium

ii) Do you currently carry general liability insurance? If yes, provide details (Insurer, limit of liability).

a. Insurer

b. Liability Limit

iii) Please indicate desired Professional Liability limit and deductible options you desire indications for:

Limit:

Deductible:

\$1,000,000 / \$1,000,000

\$2,500

\$1,000,000 / \$2,000,000

\$5,000

\$1,000,000 / \$3,000,000

\$10,000

\$2,000,000 / \$2,000,000

Other (Specify) \_\_\_\_\_

Other (Specify) \_\_\_\_\_

### Section 5: Claims Experience

a) Have any claims, suits or proceedings been made during the last five years against the Applicant, or Applicant's predecessors in business, subsidiaries or affiliated companies or against any of their past or present partners, owners, officers, sales persons or employees?

Yes  No

If yes, please complete the following Claims Supplement Form

b) Is the Applicant aware of any actual or alleged fact, circumstance, situation, error or omission which may reasonably be expected to result in a claim being made against them or any of the persons associated with the Applicant?

Yes No

If yes, please complete the following Claims Supplement Form

## Section 6: Supplementary Information

Please be prepared to provide the following information as part of this application:

- 1- Brochure/ Statement of Qualifications
- 2- Current fiscal statement
- 3- Resumes of key personnel
- 4- Copy of a standard contract

The applicant declares that, after inquiry, to the best knowledge of all persons to be insured, the statements set forth herein and in any attachments made hereto are true and no material facts have been suppressed, omitted or misstated.

Underwriters reserve the right to amend the terms, conditions and limitations of any policy issued as a result of this application, if subsequent to the date of this application, but prior to the date of such policy, there are any material alterations to the information contained herein. In the event of such material alteration, as foresaid, the Applicant agreed to give immediate written notice to Underwriters and such notice shall attach and form part of this Application.

Submitting this Application does not bind Underwriters to complete this insurance, but it is agreed that the statements and particulars contained herein will be relied upon by Underwriters should a policy be issued.

This Application is submitted on behalf of all owners, principles, partners, shareholders, directors and employees:

I/We hereby declare that the above statements and particulars are true and that I/we have not suppressed and material facts and I/we agree this declaration shall be the basis of the contract between me/us and the Underwriters.

SUBMITTING THIS FORM DOES NOT BIND THE APPLICANT TO COMPLETE THE INSURANCE. HOWEVER, IF COVERAGE IS BOUND, THIS APPLICATION BECOMES PART OF THE POLICY.

Effective Date Requested for this Insurance: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

## Supplemental Claims Application Form (If Applicable)

Full name of individual(s) and name of firm involved in claim:

Date of alleged error/ occurrence:

To which insurance Company did you report this claim?

Date reported to insurance company:

Present status of claim?  Open  In suit  Closed

Total damages paid/ outstanding:

If pending: Amount asked in summons: \$ \_\_\_\_\_

Claimants settlement demand: \$ \_\_\_\_\_

Defendant's offer of settlement: \$ \_\_\_\_\_

Description of claims, case and events: (attach necessary documents if available)

1) Do you currently have a Laboratory Liability coverage in place?  
If yes, please provide pertinent details:

Yes

No

Signed \_\_\_\_\_

Date \_\_\_\_\_

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