

To be eligible for this application you must be able to answer "True" to statements 1-7 below. Please contact our office if you are not eligible for this program. The coverage for which you are applying is limited to claims first made and reported to the Company during the Policy Period as stated in the Declarations or any applicable Extended Reporting Period.

Applicant Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Contact: \_\_\_\_\_

In lieu of mailing my policy, you may email my policy to the above address. I agree to receive an electronic copy of my application with my policy.

Date Established under Current Ownership: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

**NEW ACCOUNT:** Desired Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Retroactive Date \_\_\_\_/\_\_\_\_/\_\_\_\_ **RENEWAL:** Expiring Policy # \_\_\_\_\_

If you have a policy in force, you will need prior acts coverage. Attach a Copy of your current Declarations page showing the prior acts date. If you have coverage for any predecessor firm(s) on your current policy please provide a copy of the endorsement showing coverage for the firm.

Status of Insured:  Independent Contractor  Sole Proprietor  Partnership/LLP  Corporation/LLC

Number of professionals earning \$20,000/year or more: \_\_\_\_\_ Number of professionals earning less than \$20,000/year: \_\_\_\_\_

Annual # of Transaction Sides: \_\_\_\_\_ (on closed real estate sales) Total Gross Revenue for prior 12 months: \$ \_\_\_\_\_

To be eligible for this application and the premium options shown below you must be able to answer "True" to statements 1-7 below.

1. No owner, agent or member of the applicant company has had their license revoked, been investigated or been subject to any disciplinary action by any licensing board, real estate association or other regulatory body within the last 5 years.	<input type="checkbox"/> True <input type="checkbox"/> False
2. No owner, agent or member of the applicant company has been cancelled, refused insurance or declined by an insurance carrier during the last 5 years (except due to loss of market or non payment of premium). <b>Notice to Missouri Residents Only: This question does not apply. You will be eligible if all other questions are answered True.</b>	<input type="checkbox"/> True <input type="checkbox"/> False
3. No owner, agent or member of the company is involved in appraisal services, mortgage brokering, property management, development or construction.	<input type="checkbox"/> True <input type="checkbox"/> False
4. No single client represents more than 50% of the applicant's gross revenue and no owner or agent of the company has an exclusive listing agreement with a builder/developer.	<input type="checkbox"/> True <input type="checkbox"/> False
5. The applicant's combined total gross revenues did not exceed \$600,000.00 for the last three (3) year period (gross revenues are defined as all fees and commissions before expenses payable to employees and independent contractors).	<input type="checkbox"/> True <input type="checkbox"/> False
6. The applicant and anyone to whom this insurance will apply is not aware of any professional liability claim or any acts, errors, omission or personal injuries which might reasonably be expected to be the basis of a claim made against them within the past 5 years.	<input type="checkbox"/> True <input type="checkbox"/> False
7. No owner, agent or member of the applicant has provided services related to pre-foreclosed or bank owned properties that included involvement in any eviction procedures, delivering or negotiating cash for keys offers or property rehabilitation.	<input type="checkbox"/> True <input type="checkbox"/> False

Turn to Page 2 to Select and Circle Your Premium Option and Remit With Your Application

**SELECT AND CIRCLE YOUR DESIRED PREMIUM OPTION  
AND REMIT WITH YOUR APPLICATION**

**Claim Expenses are Outside the Limits of Liability**

Deductible Loss & Expense	\$100,000/\$300,000	\$250,000/\$250,000	\$500,000/\$500,000	\$500,000/\$1,000,000	\$1,000,000/\$1,000,000
\$0.00*	\$630	\$660	\$730	\$760	\$800
\$1,000.00	\$508	\$536	\$597	\$633	\$663
\$2,500.00	\$450	\$479	\$540	\$575	\$606
\$5,000.00	\$369	\$398	\$458	\$494	\$525

\_\_\_ **One (1) year policy term option** - - premium for the limit of liability and deductible option selected above plus any applicable State taxes or surcharges.

\_\_\_ **Two (2) year policy term option (not available with the \$0.00 deductible)\*** - - whereby your policy limits are reinstated one year from the effective date. No renewal application will be required until the two year term has expired.

**To calculate the premium for the 2 year policy term option use the rate you selected above, add any applicable State taxes or surcharges and then multiply the sum by 2 = \$\_\_\_\_\_.**

**ARKANSAS FRAUD WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**DISCLAIMER**

**COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT AND FIRM ACCEPTS NOTICE THAT ANY POLICY ISSUED WILL APPLY ON A "CLAIMS-MADE" BASIS. THE APPLICANT AND FIRM ACCEPTS NOTICE THAT THEY ARE REQUIRED TO PROVIDE WRITTEN NOTIFICATION TO THE COMPANY OF ANY CHANGES TO THIS APPLICATION THAT MAY HAPPEN BETWEEN THE SIGNATURE DATE BELOW AND ANY PROPOSED EFFECTIVE DATE. THE APPLICATION MUST BE SIGNED BY AN ACTIVE OWNER, PARTNER, PRINCIPAL, OFFICER, OR MEMBER OF THE APPLICANT.**

The undersigned is authorized by, and acting on behalf of, the Applicant and represents that all statements and particulars herein are true, complete and accurate and that there has been no suppression or misstatements of fact and agrees that this application shall be the basis of, and becomes part of, the Applicant's professional liability coverage.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*To bind coverage please send the completed application and check to your agent:*

**CBMALAGA**  
Insurance Services LLC

Return application to:  
CB Malaga Insurance Services LLC  
tel: 877-245-5887  
fax: 805-426-8540  
email: info@reproinsurance.com



# **CBMALAGA**

Insurance Services LLC

## **Premium Payment Options**

**Premium Option Selected on Application:** \$ \_\_\_\_\_  
**Processing Fee:** \$ **50.00**  
**Total Due (Premium + Processing Fee):** \$ \_\_\_\_\_

The completion of this form and remittance of payment does not bind coverage. Coverage binding is subject to approval by the insurance company.

**OPTION 1 – PAYMENT BY CHECK**

Mail your signed application and check payable to **CB Malaga Insurance Services LLC** to the following address:

**Ms. Marie Meggs  
CB Malaga Insurance Services LLC  
212 W Ironwood Dr. Ste D #176  
Coeur d'Alene, ID 83814**

**OPTION 2 – PAYMENT BY CREDIT CARD**

Send us a copy of your signed application either by **email at [info@reproinsurance.com](mailto:info@reproinsurance.com)** or by **fax at (805) 426-8540** and complete the following:

Credit Card Number: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Card Verification Code: \_\_\_\_\_ Expiration Date: \_\_\_\_ / \_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize CB Malaga Insurance Services LLC to charge my credit card provided herein for the agreed amount listed above. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_