

# Departing Attorney – Application for Lawyers Professional Liability Insurance Policy



## AMERICAN ZURICH INSURANCE COMPANY

**THIS APPLICATION IS FOR A CLAIMS-MADE AND REPORTED POLICY.  
IF ISSUED, PLEASE READ YOUR POLICY CAREFULLY.**

This document is part of the application for Lawyers Professional Liability Insurance Policy. Answer all questions. If space is insufficient to answer any question fully, attach a separate sheet.

A separate Departing Attorney Application form is to be completed by the Applicant for each Attorney leaving the firm and must be signed and dated by the departing Attorney and a principal, partner or president of the firm.

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

Current Policy Number: \_\_\_\_\_

Name of departing Attorney: \_\_\_\_\_

Date departing Attorney is leaving the firm and should be deleted from this policy: \_\_\_\_\_

1. Is the departing Attorney retiring?  Yes  No  
If YES, please have the retiring Attorney contact us for further instructions regarding the non-practicing extended reporting period. This does not apply to "Of Counsel" Attorneys.
2. Is the departing Attorney leaving to practice on his or her own?  Yes  No  
If YES, please have the departing Attorney contact us regarding the purchase of his or her own Lawyers Professional Liability Insurance Policy so that he or she may avoid a gap in coverage. This does not apply to "Of Counsel" Attorneys.
3. Is the departing attorney leaving to join another firm?  Yes  No  
If YES, please have the departing Attorney contact us regarding information concerning their prior acts coverage and the possibility of preserving that coverage at their new firm to avoid a gap in coverage. This does not apply to "Of Counsel" Attorneys.

*Please provide a forwarding address and a business phone number for the departing Attorney:*

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

City, State, Zip Code: \_\_\_\_\_

Business Phone: (     ) \_\_\_\_\_

The applicant represents that the above statements are true and correct to the best of his or her knowledge and that no material or relevant facts have been suppressed or misstated and agree that the policy, if issued, will be issued on the reliance of such representations.

Applicant acknowledges a continuing obligation to report to us as soon as practicable any material changes in the facts or statements above, and in each supplementary application, which applicant becomes aware after signing the application.

**Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime in certain jurisdictions.**

Completion of this form does not bind coverage. Applicant's acceptance of company's quotation is required prior to binding coverage and policy issuance. It is agreed that this application shall be the basis of the contract of insurance should a policy be issued and it will be attached to the policy.

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

Principal, Partner or President

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

Agent