



Minnesota Add Attorney(s) Form

Firm Name: _____ Policy Number: _____

COMPLETE THE FOLLOWING FOR EACH NEW ATTORNEY JOINING THE FIRM.

Attorney Name	Social Security Number	Years in Private Practice	Designation Code (See choices below)		Current Legal Malpractice Insurance Carrier	Current Retroactive Date

Designation Code: E = Member/Employee OC = Of Counsel/Independent Contractor
 F = Full Time P = Part Time (26 hours or fewer per week)

- Please indicate if prior acts coverage is desired for the new attorney(s):
 - NO PRIOR ACTS (If "no prior acts" is requested, there is no need to answer the remaining questions. Please sign and date the form.)
 - FULL PRIOR ACTS CONTINUE CURRENT RETROACTIVE DATE
- During the past five (5) years, has the new attorney been the subject of a reprimand, disciplinary action, or current investigation? If YES, please provide full details in an attachment on your letterhead.
 - No Yes
- Has any professional liability claim(s) or suit(s) been made against the new attorney in which the attorney, his or her firm, or an insurance company on behalf of the attorney or his or her firm paid a claim in excess of \$50,000 within the past five years OR is the attorney aware of any circumstances, incidents, acts or omissions that has led to a professional liability claim that has not yet settled or that could lead to a professional liability claim being made against your firm? If YES, complete the Claim Supplemental Application.
 - No Yes

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 Applicant: 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.

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD. A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

Signature of Owner, Officer or Partner _____	Title	Date
---	-------	------