

WORLD WIDE SPECIALTY PROGRAMS, INC.

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TOLL FREE: 800-245-9653 PHONE: 631-390-0900 FAX: 631-390-0922
www.worldwidespecialtyprograms.com

TEMPORARY HELP SERVICE ERRORS AND OMISSIONS APPLICATION

PROPOSED EFFECTIVE DATE OF COVERAGE:

1. Company's exact legal name and all trading names:

Street address:

Mailing address:

City:

State

Zip code:

Telephone: ()

No. Years in business:

Applicant is: individual partnership corporation

Are you a: franchisor franchisee independent
If you are a franchisee, please provide a copy of franchise agreement.

List professional associations to which applicant belongs:

Owner's name (if partnership, list names of all partners):

No. of offices:

List all additional locations and show percentage of ownership:

Approximate annual gross receipts: \$

Field of specialization, if any:

Please attach copy of promotional material used.

2. Limits of Liability desired (check one):

Effective date desired:

Temporary Help Service: Each wrongful act or personal injury/aggregate:

\$100,000/\$300,000

\$200,000/\$600,000

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

Higher Limits available upon request

Note: If you are engaged in permanent placements, please note a separate policy applies. Please check here if you are involved in permanent placements. **The Temporary Help Service E&O Policy doesn't cover this.**

3. A. Does applicant place temps out of state? Yes No

Out of country? Yes No

If yes, please describe operation and control:

B. Are precautions taken in placing temps where a specific skill is required? Yes No

Please describe:

C. Please provide gross payroll for three most recent calendar years and percentage and/or type of service.

		Payroll			Percentage of
		19	19	19	Number of Placements
a. Clerical	Typing/Filing				
	Secretarial				
	Mail/Inventory				
	Messenger				
	Other				
	(specify)				
b. Financial:	Bank Tellers				
	Bookkeepers				
	Financial Clerks				
c. Word Processing:	Word Processors				
	Data Entry Clerks				
	Keypunch Operators				

H. Do you contract for services from any outside nursing firms or Nurses Registry? Yes No
If yes, please describe and advise if you require they provide their own errors and omissions coverage:

I. Do you obtain Certificate of Insurance from outside nursing firms or Nurses Registry? Yes No

J. Do you require that all acts, errors or omissions which might result in an insurance claim be reported to you? Yes No

K. Do you retain records of such reports? Yes No

L. Please provide name of General Liability carrier. _____

This application is for the purposes of obtaining a quotation and does not bind the applicant or the company to complete the insurance. However, if a policy is later issued, this form shall be the basis of the contract. The undersigned applicant warrants that to the best of his or her knowledge the statements set forth herein are true. The applicant further warrants that if the information supplied on the application changes between the date of this application and the time the policy is issued, the applicant will immediately notify the company in writing of any change.

NOTICE TO NEW YORK STATE APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false material thereto, commits a fraudulent insurance act, which is a crime.

SIGNATURE OF PRINCIPAL OR OFFICER

TITLE

DATE

(11/08/07)