



SUPPLEMENT 7

“OF COUNSEL” ATTORNEYS

Please complete the following information:

OF-COUNSEL NAME:

HOURS PER WEEK WORKING FOR
APPLICANT FIRM:

Applicant hereby warrants that the statements set forth herein are true, complete and accurate and that there has been no attempt at suppression or misstatement of any material facts which are known, or should be known. Applicant agrees that this Supplemental Application shall become the basis for any coverage and part of any policy that is issued by the Company.

Date _____ Signature: _____ Title: _____