



- ACE American Insurance Company
- ACE Insurance Company of Illinois
- Atlantic Employers Insurance Company

Allied Health Entity Professional Liability Application

Effective Date Requested: _____ Date Quotation Desired: _____

Coverage Requested:	Limits Requested:
<input type="checkbox"/> Professional Liability	<input type="checkbox"/> \$1,000,000 Each Claim/ \$3,000,000 Aggregate
<input type="checkbox"/> General Liability (submit the GL supplemental application)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Umbrella Liability (submit the Umbrella application)	

Instructions:

- Please type or print clearly.
- Answer **ALL** questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.
- Provide any supporting information on a separate sheet using your letterhead and reference the applicable question number.
- Check all Yes or No answers.
- If any questions do not apply – please indicate with "N/A".
- This form must be completed, dated and signed by a principal of your facility.
- "Applicant" is defined to include the corporate entity, and its employees, volunteers, directors, officers and all others intended for this insurance coverage.

Supporting Information:

Along with this completed and signed application, prospective insureds must also submit the following information:

1. Loss Experience Details:
 - a. Historical Period: All years of practice
 - b. Incurred loss amounts: Breakdown of paid and outstanding loss amounts for indemnity and expenses.
 - c. Loss descriptions: For all losses with incurred loss amounts
 - d. Scope of Coverage: Loss experience for all insureds and coverages to be considered under this application
2. Copy of the applicant's resume/curriculum vitae
3. Current insurance policy declarations page
4. Most recent accrediting agency and state licensure report
5. Names of all entities to be covered under this policy
6. Safety program and Incident Reporting plan
7. Risk management and quality improvement plan
8. Job description of Risk Manager
9. Hold harmless agreements involving clinical services
10. Marketing brochures and literature
11. Descriptive materials provided to clients
12. Sample copies of staffing contract and patient service agreements

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The requested information is necessary before a quotation can be obtained.

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I. Contact Information

Applicant Name:			
Date Business First Established:		Employer Federal Tax ID Number:	
Mailing Address:			
Practice Address:			
County of Practice:			
Contact Name:			
Contact Phone Number:			
Contact Fax Number:			
Contact Email Address:			
Website Address:			

II. Operations

1. Organizational Structure			
A. Choose One <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> Limited Liability Co.		B. Choose One <input type="checkbox"/> Profit <input type="checkbox"/> Non-profit <input type="checkbox"/> Charitable <input type="checkbox"/> Government	
C. Have there been any changes in ownership or management in the past 12 months?			<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Identify the number of owners for the corporation or partnership			
E. Percentage of receipts obtained for the following payor categories: Medicare: _____% Medicaid: _____% Other public aid: _____% Private pay: _____%			

2. Description of Operations: (check all that apply)

<input type="checkbox"/> Home Health Care Firm	<input type="checkbox"/> Retail Pharmacy	<input type="checkbox"/> School / Students
<input type="checkbox"/> Visiting Nurse Agency	<input type="checkbox"/> Closed Pharmacy	<input type="checkbox"/> Mental Health Facility
<input type="checkbox"/> Supplemental Staffing	<input type="checkbox"/> Hospice	<input type="checkbox"/> Medical Equipment Supplier
<input type="checkbox"/> Infusion Therapy Firm	<input type="checkbox"/> Imaging Center	<input type="checkbox"/> Surgical Technicians / Assistants
<input type="checkbox"/> Nurse Registry	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other (specify): _____

3. Services Provided

Service	Percentage of total revenue	Service	Percentage of total revenue
<input type="checkbox"/> Personal Care or Companion		<input type="checkbox"/> Tracheotomy Care	
<input type="checkbox"/> Respiratory Therapy		<input type="checkbox"/> Respiratory Care	
<input type="checkbox"/> Rehabilitation		<input type="checkbox"/> Infant Care	
<input type="checkbox"/> Radiation Therapy		<input type="checkbox"/> Adult Day Care	
<input type="checkbox"/> Infusion Therapy		<input type="checkbox"/> Pediatric Care	
<input type="checkbox"/> Hospice		<input type="checkbox"/> Child Day Care	
<input type="checkbox"/> Supplemental Staffing		<input type="checkbox"/> Medical Equipment Supplier	
<input type="checkbox"/> Skilled Care in Nursing Homes		<input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Obstetrical Services		<input type="checkbox"/> Closed Pharmacy	
<input type="checkbox"/> Training Consultants		<input type="checkbox"/> Other Services (please specify)	
<input type="checkbox"/> Meals on Wheels			

4. Specialty Services

A. Does the Applicant provide Pediatric Care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. How many employees provide pediatric services?		
ii. What type of services are provided?		
iii. Do you take on tracheotomy/ventilator dependent patients? If yes what is the percentage?		
iv. What is the level of specialized training and experience required?		
v. What percentage of nurse providers meet this requirement?	%	
If Apnea Monitors are used:		
i. Number of Monitors owned by Applicant:		
ii. Does the Applicant rent this equipment to others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iii. What are the qualifications of the individuals providing this service?		
B. Does the Applicant provide Psychiatric Care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. What are the qualifications of the nursing staff providing psychiatric care?		
ii. Who is responsible for assessing a patient's mental status and developing a treatment plan for home care?		
C. Does the Applicant provide Home Healthcare Services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. Total Revenue from Home Healthcare services?		
ii. Does the Applicant provide any 24-hour services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iii. Does the Applicant provide any "live-in" services? If yes, please provide the following information: The percentage of patients that utilize this service. The percentage of Alzheimer, quadriplegic, mentally incapacitated patients. The description of services provided.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
iv. Current number of patients treated in their homes: Total Number of Patients: _____ Percentage under 18 years of age: _____ % Percentage Adult (19-65): _____ % Percentage Senior (over 65): _____ %		
v. Does the Applicant provide a flu shot program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
vi. Are employees required to complete daily work reports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

vi. Methadone Maintenance Program If yes, please contact your Agent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
vii. Crisis Hotline Number of calls received annually: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
viii. Any of the following Services: Training/Staff Development/Program Design/Consultation Legal/Financial Referrals Credentialing/Peer Review Other Third Party Administration	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

III. Exposures

1. Describe the Management Services provided for others, if any.		
2. Gross Receipts: Prospective Annual period: Prior Year:		
3. Does the Applicant provide surgical services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Does the Applicant provide services to any of the following: <input type="checkbox"/> Nursing home, Assisted Living Facility or other Long Term Care Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Registry <input type="checkbox"/> Supplemental Staffing Agency <input type="checkbox"/> Prison <input type="checkbox"/> High tech Services <input type="checkbox"/> Methadone Clinics		
5. Does the Applicant engage in the following: <input type="checkbox"/> Formal clinical research under the auspices of an institutional review board <input type="checkbox"/> Administration of non-FDA approved pharmaceuticals (experimental drugs) <input type="checkbox"/> Biomedical device research and development <input type="checkbox"/> Animal Research <input type="checkbox"/> Teaching Affiliations <input type="checkbox"/> Revenue Affiliations (i.e. Joint Venture, PPO HMO, etc) <input type="checkbox"/> Medical and/or Surgical experimentation that is not approved by an Institutional Review Board		
7. Will new services be provided in the next 12 months? Will any services be discontinued in the next 12 months? Have any services been discontinued in the last 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
8. Within the next 12 month period, does the Applicant plan to: Obtain another operation or entity? Add to the number of employees? Expand the number of locations?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
9. Does the Applicant act as or provide services for managed care organizations? If Yes, does the Applicant take any risk under a capitation arrangement with these organizations?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
10. Does the Applicant own or manage any residential facilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Does the Applicant prescribe medications to patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Does the Applicant utilize recreational activities in the treatment of patients?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

IV. Professional Employees and Staff

1. Is the Applicant responsible for the hiring and supervision of the Independent Contractors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the Applicant employ foreign trained professionals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If Yes, what percentage of employees are foreign trained: _____%		
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3. Complete the following for contracted physicians:

Name	Specialty	Board Certified	Board Eligible	Hours worked weekly	Does Physician carry own Malpractice Ins?	Carrier, Limits & Effective Date

4. Census of Professional Employees/Independent Contractors

Professional Classification	Total Number of Hours Worked Weekly	Number of Employees		Number of Contractors		Annual Payroll
		FULL	PART	FULL	PART	
Addiction Counselor (NAADAC Program) (1)						
Addiction Counselor (Non-NAADAC)						
Addiction Interventionist						
Administrative/Clerical						
All other Aide, Assistant, or Technician						
Art, Music, Dance, Pet, and Recreation Therapist						
Audiologist						
Auricular & Full Body Acupuncture Therapy and Counseling						
Auricular Acupuncture Therapy and Counseling						
Behavioral Analyst						
Blood Bank Technician						
Cardiology Technician						
Case Workers and Case Manager						
Certified Employee Assistance Professional						
Certified Tech./ Assistant						
Companion						
Cytotechnologist						
Dental Assistant						
Dental Hygienist						
Dialysis Technician						
Dietician/Nutritionist						
EKG/EEG Technician						
Health Educator						
Home Health Aide						
Homemaker						
Intern Mental Health/Addiction Counselor						
Lab Technician						
Licensed or Certified Mental Health Counselor						

LPN						
Marriage and Family Therapists/Counselor						
Massage Therapist						
Medical Office Assistant						
Medical Records Technician						
Medical Technologist						
MRI Technician						
Nurse Aide						
Nurse Practitioner						
Nurse/RN						
Occupational Therapist						
Paramedics/EMTs (Eligible for Students Only)						
Pastoral Counselor						
Pathology Assistant						
Patient Intake Technician						
Personal Coach						
Pharmacist (Mail Order, Nuclear)						
Pharmacist (Non-Mail Order – Non-Nuclear)						
Pharmacy Assistant						
Pharmacy Technician (Dispensing)						
Phlebotomist						
Physical Therapist						
Physician's Assistant						
Psychological Assistant (Masters Degree)						
Psychologist (Bachelors or Masters Degree)						
Psychologist (Doctorate Degree)						
Radiological Technologist						
Rehabilitation Counselor/Therapist						
Rehabilitation Counselor/Therapist Assistant						
Respiratory Assistant						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Surgical Assistant						
Surgical Technologist						
Surgical Technologist/First Assistant						
Ultrasound Technician						
Utilization Review Technician						
Volunteer						
Wellness Counselor						
X-Ray Machine Operator/Technician						
Other:						

V. License/Certification Information

1. Licensed Specialty:		
2. Licensing Agency:		
3. Applicant Accreditation:	Date Surveyed:	Score:
4. List any other professional degrees, licenses or certifications obtained by Applicant?		
5. Has a professional licensing board, certification board or professional ethics board taken disciplinary action against the Applicant? Are any disciplinary actions pending?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
6. Has the Applicant ever surrendered their license for any reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has the Applicant's License or Certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? Are any such charges pending against the Applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
8. Is the Applicant licensed in all states in which it is operating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VI. Risk Management

1. Has the Applicant ever been convicted of a misdemeanor or felony or is any such charge pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has any hospital or other healthcare entity ever denied, suspended, non-renewed, revoked, declined or in any way restricted the Applicant's privileges? Has any hospital or other healthcare entity invoked probation against the Applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
3. Are complete records kept on all patients? If so, are they stored in locked cabinets/rooms? Does the Applicant require signed release forms for the release of records?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
4. Has the Applicant ever had an incident that resulted in an allegation of sexual abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Does the Applicant have a drug or alcohol addiction or dependency now or in their history?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Is an informed consent process in place?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has the Applicant ever been investigated by a State Health Department, State Licensing Board, or other Governmental Body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the Applicant conduct patient/client surveys?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Are written policies and procedures in place regarding the following:		
Advance Directives/Living Wills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient Acceptance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Incident Reporting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Record Documentation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acceptance of verbal physician orders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Administration Procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient Rights	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient Discharge Procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Handling of Complaints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employee Training	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lifting Requirements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food Preparation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Equipment Training	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chain of Command	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Reporting of Suspected Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is compliance with these policies enforced and monitored?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VII. Employment Practices

1. Does the Applicant perform criminal background checks on prospective employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are job descriptions provided for all professional and nonprofessional employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do employees actively participate in continuing educational programs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Does the Applicant verify employment related references?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Does the Applicant conduct personal interviews?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the Applicant verify certification and/or professional licensure status of employees and independent contractors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the Applicant confirm in writing any of the following related to prospective employees: Whether their medical professional liability insurance has been denied or cancelled? (Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.) Whether they have been involved in any professional liability claims or litigation? Whether any action has ever been taken on their clinical privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
8. Does the Applicant have a supervision plan to monitor staff? If yes, does the plan include surprise checks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Are employees screened to rule out drug, alcohol abuse? Are employees screened to rule out any allegations against them involving sexual abuse or molestation?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
10. Does the Applicant have a written crisis management plan for dealing with staff, victims, parents, authorities and media if you have an incident of abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VIII. Professional Liability Insurance Coverage Information: (Please list the last 3 years starting with the current.)

Policy Period	Carrier	Limits	Retention	Premium	CM/Occ
					<input type="checkbox"/> Claims Made Retro date: _____ <input type="checkbox"/> Occurrence
					<input type="checkbox"/> Claims Made Retro date: _____ <input type="checkbox"/> Occurrence
					<input type="checkbox"/> Claims Made Retro date: _____ <input type="checkbox"/> Occurrence

1. Date of Applicant's first claims made Professional Liability Policy:	
2. Has the Applicant been continuously insured under a claims made professional liability policy since this date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the Applicant subject to a patient's compensation fund?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the Applicant ever had professional liability insurance canceled or non-renewed? (Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions. Nevada Applicants: If you have answered Yes, please provide an explanation.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

IX. Incident or Claim Information

1. Are you aware of any of the following events:		
a. Any deaths of clients/patients reported while they were in your care or under your supervision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Any incidents including slips, trips or falls of a client or patient reported?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Any mistaken procedures executed or incorrect diagnoses rendered?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Any severe drug reaction by a client or patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you aware of any events where patients or their relatives have:		
a. Directly accused you or your employees of malpractice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Exhibited a total disregard of advice or irrational expectations of cure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Abruptly discontinued care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Repeated complaints about service or treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has any patient requested release of their records to an attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has any professional liability claim or suit ever been made against any Applicant/employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Is the Applicant aware of any fact, circumstance or situation which may lead to any future claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

X. Fraud Prevention and Signature

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for 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.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO LOUISIANA APPLICANTS: 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.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MINNESOTA APPLICANTS: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: 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 civil fines and criminal penalties.

NOTICE TO NEW YORK 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 materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA 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 materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE & VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant

Signature of Broker/Agent

Title

Date

Broker/Agent License Number:

Date

Signed by Licensed Resident Agent

(Where Required By Law)