



# Allied Healthcare Professional and General Liability Product

This is an application for a claims made (professional) and occurrence (general liability) policy. Please read your policy carefully. Defense costs shall be applied against the deductible.

## SECTION I. PROFESSIONAL LIABILITY UNDERWRITING INFORMATION

Name of applicant: \_\_\_\_\_ dba: \_\_\_\_\_  
Location address: \_\_\_\_\_  Same as mailing address  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Web address: \_\_\_\_\_ Email address of primary contact: \_\_\_\_\_ Number of locations \_\_\_\_\_,  
% of services rendered outside the U.S.A., if any \_\_\_\_\_%

Please complete this section for the applicant and the applicant's staff: <b>Professional Classification</b>	Employer (break out owners/ partners/directors/ officers by professional classification)		Employees (break out by professional classification)		Self employed or independent contractors (break out by professional classification)		*Other	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time

**Employer** means an entity/organization with employees and/or independent contractors.  
**Employee** means an individual working for and receiving an IRS Form W-2 from an entity/organization he/she does not own.  
**Self-employed** means an individual who performs professional services for others without employees or independent contractors.  
**Independent contractor** means an individual who performs professional services for others and receives an IRS Form 1099 for compensation paid.  
**Part Time** means less than 1000 hours worked per year.  
\*Describe "other" classification if used above \_\_\_\_\_  
If applicant is an employee or independent contractor, advise employer name, city and state \_\_\_\_\_

- How long has the applicant been providing the professional services listed above? \_\_\_\_\_
- Do all professionals listed above, for whom coverage is sought, have a current, unrestricted license or its equivalent as required under federal or state law and/or the rules and regulations of the profession?  Yes  No  Not Required
- List license(s) and degree(s) or equivalents held by each professional listed above:  
\_\_\_\_\_
- Does the applicant have any ownership, interest in, operate, administer or perform services as any laboratory, hospital, emergency room or nursing home or similar operation now or in the next 12 months?  Yes  No
- Is applicant controlled, owned, affiliated or associated with any firm, corporation or company not identified in this application?  Yes  No  
If yes, please provide details \_\_\_\_\_
- Does the applicant have any subsidiaries for which coverage is sought?  Yes  No  
If yes, please provide the name, percentage owned and professional classification of each subsidiary and include them in the list of professions above: \_\_\_\_\_
- Number of patient/client visits recorded by applicant in past 12 months? \_\_\_\_\_ Number of visits anticipated next 12 months? \_\_\_\_\_
- Do any professionals for whom coverage is sought provide, practice, perform, administer or assist in any of the following now or expect to in the next 12 months:
  - Surgery or surgical procedures including pre-operative and post operative procedures?  Yes  No
  - Injections of any kind?  Yes  No
  - Diagnosing conditions, disorders or diseases in patients?  Yes  No

- d) Services as a physician, surgeon, nurse, anesthetist, anesthesiologist, psychiatrist, chiropractor, acupuncturist, pharmacist, dentist?  Yes  No
- e) Emergency, overnight or 24 hour call services?  Yes  No
- f) Designing, testing or manufacturing products of any kind including vitamins, minerals, herbal, medicinal or nutritional supplements?  Yes  No
- g) Transporting clients/patients?  Yes  No
- h) Prescribing, monitoring or dispensing medication, equipment, devices or appliances whether over-the-counter or not?  Yes  No
- i) Providing Professional Services within any prison facility/correctional facilities or with prison release or probation programs?  Yes  No

If yes to any of the above, describe service(s) provided and percentage of patients/clients receiving each service(s):

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- 9. Are criminal background checks and license verifications conducted for all professionals?  Yes  No
- 10. Does the applicant obtain a written informed consent to services from clients (parents/guardians must sign for minors)?  In all cases  Sometimes  Never
- 11. List additional insured(s) required by contract to be included for professional liability coverage:

Name	Address	Relationship to Applicant

**Attach a statement of details for all "Yes" answers to the following questions.**

- 12. (a) Has the applicant or any professional listed above had a professional license or its equivalent denied, revoked, restricted, suspended; been fined or disciplined in any way or been the subject of any investigation by any authority for any reason, including but not limited to allegations of sexual abuse?  Yes  No
- (b) Are any such actions pending as of the date of this application?  Yes  No
- 13. Has the applicant initiated litigation against any patients or clients in the past five years? (if yes, provide names, dates, status of litigation and demand amount)  Yes  No
- 14. In the past five years, has any claim been made or suit brought against the applicant, its predecessor(s) in business or any of its present or former owners, partners, officers, directors, employees or independent contractors?  Yes  No
- 15. Is the applicant or any person proposed for this insurance aware of any circumstance, allegation, contention or incident which may result in a claim being made against the applicant or any person proposed for this insurance?  Yes  No
- 16. Has any policy of professional liability insurance ever been cancelled or non-renewed by an insurance carrier? (Not applicable in Missouri) If yes, provide details \_\_\_\_\_  Yes  No
- 17. (a) Does the applicant currently have professional liability insurance in force?  Yes  No
- General liability insurance in force?  Yes  No

If yes, specify:

Name of Professional Carrier	Limit	Retroactive Date (if any)	Deductible	Annual Premium	Policy Period	Claims Made (C) or Occurrence (O)
Name of General Liability Carrier	Limit	Retroactive Date (if any)	Deductible	Annual Premium	Policy Period	Claims Made (C) or Occurrence (O)

(b) Number of years continuous, uninterrupted insurance coverage? Professional liability: \_\_\_\_\_ General liability \_\_\_\_\_

- 18. Does applicant agree to maintain commercial general liability insurance?  Yes  No  Not applicable
- If no, explain \_\_\_\_\_
- 19. Does the applicant verify that all independent contractors working on their behalf maintain commercial general liability insurance with limits equal to or greater than the limits of professional liability insurance provided?  Yes  No
- If no, explain \_\_\_\_\_
- 20. Does the applicant require coverage for any independent contractors under this policy?  Yes  No

**SECTION II. GENERAL LIABILITY UNDERWRITING INFORMATION (complete only if seeking this coverage)**

- 1. Any general liability claims against applicant (paid, reserved or pending) in the past five years?  Yes  No
- If Yes, please provide details. \_\_\_\_\_
- 2. Additional insured(s) to be included for general liability coverage:

Name	Address	Relationship to Applicant

- 3. Has any general liability policy been cancelled or non-renewed by an insurance carrier?  Yes  No (Not Applicable in Missouri)
- If yes, provide details \_\_\_\_\_
- 4. How many square feet is the applicant's operation? \_\_\_\_\_
- 5. Does applicant have ownership in the structure being Insured?  Yes  No

### SECTION III: REQUIRED INFORMATION

A. USLI application.

B. Supplemental application (for select classes)

**Arizona Notice:** Misrepresentations, omissions, concealment of facts and incorrect statements shall prevent recovery under the policy only if the misrepresentations, omissions, concealment of facts or incorrect statements are; fraudulent or material either to the acceptance of the risk, or to the hazard assumed by the insurer or the insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.

**Florida and Illinois Notice:** I understand that there is no coverage for punitive damages assessed directly against an insured under Florida and Illinois law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida and Illinois law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida and Illinois is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages

**Minnesota Notice:** Authorization or agreement to bind the insurance may be withdrawn or modified only based on changes to the information contained in this application prior to the effective date of the insurance applied for that may render inaccurate, untrue or incomplete any statement made with a minimum of 10 days notice given to the insured prior to the effective date of cancellation when the contract has been in effect for less than 90 days or is being canceled for nonpayment of premium.

**Missouri Notice:** Pursuant to Section IV, Paragraph R., some Defense Costs are within the Limit of Liability. Any Defense Costs paid under this coverage will reduce the available Limits of Insurance and may exhaust them completely. Defense Costs means reasonable and necessary legal fees and expenses incurred by the Company, or by any attorney designated by the Company to defend any Insured, resulting from the investigation, adjustment, defense and appeal of a Claim. Defense Costs includes other fees, costs, costs of attachment or similar bonds (without any obligation on the part of the Company to apply for or furnish such bonds), but does not include salaries, wages, overhead or benefits expenses of any Insured.

**New York Disclosure Notice:** *This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged Wrongful Acts or Wrongful Employment Acts that took place prior to retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect for incidents reported during the Policy Period or any subsequent renewal of this Policy or any extended reporting period and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extend reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims-made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.*

**Utah Notice:** I understand that Punitive Damages are not insurable in the state of Utah. There will be no coverage afforded for Punitive Damages for any Claim brought in the State of Utah. Any coverage for Punitive Damages will only apply if a Claim is filed in a state which allows punitive or exemplary damages to be insurable. This may apply if a Claim is brought in another state by a subsidiary or additional location(s) of the Named Insured, outside the state of Utah, for which coverage is sought under the same policy

**Virginia Notice:** This Policy is written on a claims-made basis. Please read the policy carefully to understand your coverage. You have an option to purchase a separate limit of liability for the extended reporting period. If you do not elect this option, the limit of liability for the extended reporting period shall be part of the and not in addition to limit specified in the declarations. If you have any questions regarding the cost of an extended reporting period, please contact your insurance company or your insurance agent. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

**Colorado Fraud Statement:** 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.

**District of Columbia Fraud Statement: 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.

**Florida Fraud Statement:** 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.

**Kentucky Fraud Statement:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**Maine and Washington Fraud Statement:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**New Jersey Fraud Statement:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New York Fraud Statement:** 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.

**Ohio Fraud Statement:** Any person who, with 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.

**Oklahoma Fraud Statement: 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.

**Pennsylvania Fraud Statement:** 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.

**Tennessee and Virginia Fraud Statement:** 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.

**Vermont Fraud Statement:** 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 may be subject to fines and confinement in prison.

**Fraud Statement (All Other States):** 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.

If your state requires that we have information regarding your Authorized Retail Agent or Broker, please provide below.

Retail Agency Name: \_\_\_\_\_ License #: \_\_\_\_\_

Main Agency Phone Number: \_\_\_\_\_

Agency Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a policy be issued and it will be attached and become a part of the Policy.

Applicant's Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Principal, Officer or Partner