Agent Name:_____
Agent Number:_____

THE MEDICAL PROTECTIVE COMPANY

(a Stock Company)

WELLNESS & FITNESS PROFESSIONAL
OCCURRENCE
PROFESSIONAL LIABILITY AND GENERAL LIABILITY GROUP INSURANCE APPLICATION

I. General Information

Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

A. _____
Entity Name

_____
If the entity does business under any other name, list additional entity name(s), DBA, fictitious name, etc.

_____
Primary Contact Name

_____ _____ _____
Street Address Apartment/Suite # City

_____ _____ _____ _____
County State Zip Code State of Incorporation

_____ _____
Federal Tax ID Number Date Entity Formed (MM/DD/YYYY)

_____-_____-_____ _____
Phone Email

How did you hear about CPH? _____

B. **Requested Effective Date:** _____ /_____ /_____
MM DD YYYY

C. **Desired Professional Liability Limits:**
Requested limits options may not be available in your state.

__ $1,000,000/$3,000,000 __ $1,000,000/$6,000,000 __ Other: _____

D. **Is this entity being added to a current Medical Protective Insured's policy?** __ Yes __ No

If yes, please select one of the following:

____Add this entity on a "Shared Limit" basis. (Not available in some states.)

____Add this entity with an additional "Separate Limit" for an additional charge.

II. Optional Coverages

A. **Would you like to purchase General Liability coverage (Bodily Injury and Property Damage)?** __ Yes __ No

B. **Are you required by contract to name an Additional Insured on your Professional and/or General Liability policy?** __Yes __ No

Please note that coverage is limited to the Additional Insured's vicarious liability based solely on professional services rendered, or which should have been rendered, by the affiliated Named Insured.

If yes, please provide the information requested below. If you have more than one Additional Insured that is required by contract to be named on your policy, please provide their name, mailing address and nature of professional relationship to you on a separate sheet.

Additional Insured Name: _____

Mailing Address: _____
Street City State Zip Code

Nature of Professional Relationship to you: __ Landlord __ Employer __Contracting Agency __Other

III. Practice Information

A. Roster of Staffing

	W-2 Employees* Please indicate the number of W-2 Employees, including owners.	
	Full-Time Status (more than 24 hours a week)	**Part-Time Status** (less than 24 hours a week)
Aerobics Instructor		
Athletic Trainer		
Certified Personal Trainer		
Dance Therapist		
Dietician		
Exercise Physiologist		
Fitness Professional		
Group Fitness Instructor		
Health Educator		
Heller Worker		
Kinesiologist		
Massage Therapist		
Nutritionist/Certified Nutritional Consultant		
Pilates Instructor		
Reiki Practitioner		
Rolfer		
Sports Medicine Instructor		
Sports Medicine Therapist		
Structural Body Worker		
Student		
Wellness Counselor		
Yoga Instructor		
Yoga Therapist		
Other (please include a job description/credentials on separate sheet)		
Total:		

Note: Independent contractors are unable to be insured under this policy. The entity applying for coverage will have vicarious liability coverage for the independent contractor's acts, subject to the terms and conditions of the policy.

B. Are all employee professional designations/certifications or training currently valid? __ Yes __ No

If no, please explain: _____

C. Has the entity or any of the entity's employees ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses? __ Yes __ No

If yes, please indicate the entity's name(s) or entity's employees' name(s), the date(s) and explain.

Name: _____ Date: _____ / _____ Explain: _____
MM YYYY

D. Has any of the entity's employees ever been accused of sexual misconduct of any kind? __ Yes __ No

If yes, please indicate the entity's employees' name(s), the date(s) and explain.

Name: _____ Date: _____ / _____ Explain: _____
MM YYYY

E. Has the entity or any of the entity's employees ever had their designation/certification/professional license refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? __ Yes __ No

If yes, please indicate the entity's name(s) or entity's employees' name(s), the date(s) and explain.

Name: _____ Date: _____ / _____ Explain: _____
MM YYYY

F. Has any of the entity's employees ever incurred or become aware of having a condition that impairs their ability to practice their specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics or other controlled substances, etc.) __ Yes __ No

If yes, please indicate the entity's employees' name(s), the date(s) and explain.

Name: _____ Date: _____ / _____ Explain: _____
MM YYYY

G. Has any professional liability insurance company, general liability insurance company or other insurance company for any coverage that is being requested by Medical Protective ever declined, refused, canceled or non-renewed the entity or any of the entity's employees' coverage? __ Yes __ No
NOTE: MISSOURI RESIDENTS DO <u>NOT</u> RESPOND.

If yes, please indicate the entity's name(s) or entity's employees' name(s), the date(s) and explain.

Name: _____ Date: _____ / _____ Explain: _____
MM YYYY

IV. Loss Information

Please complete a Loss Information Supplement for each written request, incident, claim or suit involving professional liability, general liability or any coverage you are requesting from Medical Protective.

A. Has the entity or any of the entity's employees currently or ever been, subject to a written request or demand, or involved in an incident, claim, or suit, arising out of the rendering or failure to render professional services or related to any other coverage you are requesting from Medical Protective? __ Yes __ No

If yes, how many? _____

B. Has the entity or any of the entity employees become aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against the entity or any of the entity employees? This includes all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit. __ Yes __ No

If yes, how many? _____

V. Important Notice – Representations, Authorizations, Releases and Notices

MANDATORY: *ALL APPLICANTS must read the following statement carefully <u>unless</u> in a state listed below:*
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, which may include voiding of the policy if allowed by state law.

ALL ALABAMA APPLICANTS:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALL ARIZONA 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.

ALL ARKANSAS 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.

ALL 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 with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulated Agencies.

ALL DISTRICT OF COLUMBIA APPLICANTS:
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.

ALL 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.

ALL GEORGIA 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 may include imprisonment, fines, or denial of insurance benefits.

ALL 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.

ALL KANSAS APPLICANTS:
An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

ALL KENTUCKY APPLICANTS:
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.

ALL MAINE 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 may include imprisonment, fines, or denial of insurance benefits.

ALL MINNESOTA APPLICANTS:
No oral or written misrepresentation made by the Insured, or in the Insured's behalf, in the negotiation of insurance, shall be deemed material, or defeat or avoid the policy, or prevent its attaching, unless made with intent to deceive and defraud, or unless the matter misrepresented increases the risk of loss.

ALL 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.

ALL 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.

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

ALL OKLAHOMA APPLICANTS:
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.

ALL OREGON APPLICANTS:
Any person who knowingly files an application for insurance or a statement of a claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

ALL 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.

ALL RHODE ISLAND 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.

ALL TENNESSEE 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, or denial of insurance benefits.

ALL VERMONT APPLICANTS:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

ALL 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, or denial of insurance benefits.

ALL WASHINGTON 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, or denial of insurance benefits.

ALL WEST VIRGINIA 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.

VI. Notices and Agreements

By my signature, I hereby represent that all applicants have granted me full authority to execute this application on his, her or the entity's behalf and I am authorized to represent and sign on behalf of anyone from my practice. I also represent that I have reviewed the responses contained in this application with the applicants, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicants and that they understand and agree that such representations are binding upon him, her or the entity, even though I am executing this application on the applicants' behalf.

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments")** for the purposes of my, or any applicants' initial or renewal application, are true and that I, nor any applicant, have not knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments,** shall be the basis of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments,** including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare professional, facility, firm or professional association.

Where allowed by state law, I understand that any material misrepresentation or omission made by me or any other applicant on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I or any applicant understands that if payment of premium or first installment is by check, electronic transfer or money order, it shall not be considered "received" by the Company until it has been honored by the bank.

I AGREE THAT IF I, OR ANY APPLICANT, FAIL TO COMPLY WITH THESE TERMS WE **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

I, or any other applicant, understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me or any applicant, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

By signing this application on behalf of a group, or an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

I represent that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

If Arizona: I understand that, to the extent permitted by law, the Company reserves the right to deny coverage for any claim submitted under this policy if I have made misrepresentations, omissions, or incorrect statements, or if I have concealed facts that are: (1) fraudulent; (2) material either to the acceptance of the risk or to the hazard assumed by the Company; and (3) the Company in good faith would either not have issued the policy, or would not have issued the 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 Company as required either by this application for the policy, subsequent notice, or otherwise.

If California: I understand that if I cancel or terminate any coverage that may be provided by the Company, earned premium shall be computed in accordance with the standard short rate tables and procedures with a maximum penalty of up to 11%. Premium adjustments shall be made within a reasonable period of time after cancellation or termination. However, payment or tender of unearned premium shall not be a condition of cancellation.

If Delaware: Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy or contract unless either: (1) Fraudulent; or (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or (3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate or would not have issued a policy or contract 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 contract or otherwise.

If Georgia: I understand that any material misrepresentation or omission made by me on this application may provide the Company with the right to cancel the policy and/or deny coverage for any claim submitted under this policy if I have made misrepresentations, omissions, or incorrect statements, or if I have concealed facts that are: (1) fraudulent; (2) material either to the acceptance of the risk or to the hazard assumed by the Company; and (3) the Company in good faith would either not have issued the policy, or would not have issued the 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 Company as required either by this application for the policy, subsequent notice, or otherwise. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Illinois: I understand that any material misrepresentation or omission made by me or any other applicant on this application, which was omitted or made with the intent to deceive or which materially affects the acceptance of the risk or hazard assumed by the Company, may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.
I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my

completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, my policy shall not be deemed to have been issued or delivered and shall not be applicable to any matter which may have been covered under the policy if the payment is later dishonored by the bank.

If Kansas: An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

If Maine: I understand that any material misrepresentation or omission made by me on this application may cause coverage to be cancelled and/or denied. However, we maintain the right to request a ruling from the Maine Courts on voidance or rescission of this policy. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Oklahoma: I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

If Vermont: I understand that any material misrepresentation or omission made by me or any other applicant on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to cancel it. By making this application, I am not, nor is any other applicant relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

If Washington: I understand that any intentional concealment or material misrepresentation made by me, or someone acting on my behalf, on this application may act to render any contract of insurance null and without effect. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

The Delaware Civil Union & Equality Act of 2011

The Medical Protective Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 and Delaware Bulletin No. 46 including the following:

Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

Compliance with Illinois Bulletin 2011-06 and The Religious Freedom Protection and Civil Union Act

The Medical Protective Company recognizes the rights afforded to individuals under The Religious Freedom Protection and Civil Union Act which states:

"The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married." or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA INSURANCE GUARANTY ASSOCIATION LAW

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
7600 Parklawn Ave # 460
Edina, MN 55435-5137
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to $300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any

exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

Application must be signed by the Individual Applicant, a President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

Authorized Representative Signature/Title

Date Signed (MM/DD/YYYY)

Print Name

Agent Name & License Number (required for IA):

(Signature)