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

_____ _____ _____ _____
Parish 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 LOUISIANA APPLICANTS must read the following statement carefully:*
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.

I understand that any material misrepresentation or omission made by me or any other applicant on this application, with the intent to deceive, 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.

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