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Professional Liability Insurance Application for Individual Allied Healthcare Professionals

Apply online at LocktonMedicalLiabilityInsurance.com/IICT to save yourself time and money. Paper applications require a $20 processing fee.

THIS IS A CLAIMS MADE AND REPORTED POLICY. SUBJECT TO ITS TERMS, THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE UNDERWRITERS DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE. DAMAGES AND CLAIMS EXPENSES SHALL BE APPLIED AGAINST THE DEDUCTIBLE. CLAIMS EXPENSES ARE WITHIN AND REDUCE THE LIMIT OF LIABILITY UNDER THIS POLICY. THE UNDERWRITERS SHALL NOT BE LIABLE FOR ANY CLAIMS EXPENSES OR FOR ANY JUDGEMENT OR SETTLEMENT AFTER THE LIMIT OF LIABILITY HAVE BEEN EXHAUSTED. PLEASE READ THIS POLICY CAREFULLY.

Section I: APPLICANT INFORMATION

What is your Allied Healthcare occupation? (Find a complete list of occupations eligible for coverage at LocktonMedicalLiabilityInsurance.com/IICT)

_____

(Not all occupations qualify for coverage. You must hold a valid license or certificate if required by federal, state or local regulations for each occupation requested.)

Are you a member of any professional association related to your occupation? ☐ Yes ☐ No

If yes, provide Association name: _____ Member number: _____

Applicant Name (First/Last): _____

Business Name (optional): _____

If you are the sole owner of your business and have no employees, your business name will also be listed as a Named Insured on your policy. If you do not own 100% of your business or if you have employees or other associated individuals providing services on your behalf, please complete the Group Coverage application, which can be downloaded at LocktonMedicalLiabilityInsurance.com/IICT.

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Section II: EMPLOYMENT/OCCUPATION INFORMATION

How many years of relevant experience do you have? (Include any time you may have worked under supervision)

☐ Greater than 1 year, less than two years
☐ Greater than 2 years, less than three years
☐ Greater than 3 years

How many hours do you work per week? _____

Select your status: (If you are both employed and self-employed, please select self-employed)

☐ Employed (you provide services on behalf of an entity you do not own, and receive a W-2 form from your employer)
☐ Self-Employed Full-time (you provide services as an independent contractor, and pay self-employment taxes using a 1099 form)
☐ Self-Employed Part-time (less than 25 hours a week)
☐ Student - Anticipated Graduation Date: _____ / _____ / _____

Have you obtained secondary certification or licensure or had more than four hours of continuing education on risk management, ethics, or legal issues relevant to your profession within the past 12 months? You may be eligible for a discount. ☐ Yes ☐ No

If yes, list the Name of Organization _____
Date of Certification or Continuing Education _____(mm/dd/yyyy)

This policy does not provide coverage for the following exposures. Please review the list carefully.

- Professional services to residents in/on the premises of any long-term care facility, i.e. nursing home or residential care facility
- Youth-focused overnight professional programs such as Outward-Bound, boot camps, etc.
- Professional services to professional athletes whose annual income is $25,000 or greater
- Jobsite training or consulting that would normally be performed on a construction jobsite or in a manufacturing or factory setting by a safety inspector, safety trainer, or environmental inspector or consultant.

Do you provide ANY of the above services? ☐ Yes ☐ No

If yes, please contact Lockton Affinity at Lockton_Info@LocktonAffinity.com or (800) 253-5486 .

Have you used or do you plan to use any life sustaining or critical life monitoring equipment or devices in your practice other than emergency defibrillation devices, i.e. an Automated External Defibrillator (AED)? This includes oxygen and other medical gases used in conjunction with respiratory therapy, dialysis or heart lung machines, SIDS monitors or any other life dependent monitors or equipment or devices that malfunction and could result in death or serious deterioration of a patient's health condition. ☐ Yes ☐ No

Section III: PROFESSIONAL LIMITS AND COVERAGE

Select the limits you require:

☐ $2,000,000 / $4,000,000
☐ $1,000,000 / $3,000,000
☐ $1,000,000 / $1,000,000
☐ $500,000 / $500,000

Are you listed as the Named Insured on another active Professional Liability policy that provides coverage for the same occupation and offers claims made coverage? ☐ Yes ☐ No

Would you like to purchase a policy that provides coverage for prior incidents by matching your current policy's Prior Acts/Retroactive date? ☐ Yes ☐ No

If "Yes" to both questions above, please provide a copy of your current Claims Made Declarations Page, an endorsement listing your prior acts retroactive date or complete the following:

Insurance Company Name: _____
Policy Expiration Date: _____(mm/dd/yyyy)
Policy Prior Acts/Retroactive Date: _____(mm/dd/yyyy)

If "No" to either of the above, the Policy Prior Acts/Retroactive Date will be the policy effective date.

**NOTE: You will need to provide Underwriters with a copy of your expiring policy to verify your current prior acts retroactive date should a claim be presented in the future under this program.*

Section IV: ADDITIONAL INSUREDS TO BE INSURED

Additional Insureds must have a valid insurable interest or a written requirement to be included on your insurance. Please describe the business relationship or insurable interest of the Additional Insureds using the list below*.

Name of Additional Insured	Is the Additional Insured an Organization or an Individual?	Complete Address of Additional Insured	Business Relationship/Insurable Interest: (enter the applicable number(s) from the list below or explain)

***For Business Relationship, choose from the following: (1)** Co-Owner Of Insured Premises **(2)** Grantor Of Franchise **(3)** Land Owner Lessor Of Leased Equipment Lessor of Premises **(4)** Managers of Premises used for providing Professional Services **(5)** Mortgagee, Assignee, Or Receiver **(6)** Owner Or Other Interests From Whom Land Has Been Leased **(7)** I am in a contractual agreement with the requested Additional Insured to name them as such **(8)** They are my employee or independent contractor **(9)** Other; please describe.

CERTIFICATE HOLDER
If you are required by contract to provide Proof of Coverage to a third party, provide the required information below. (A Proof of Coverage Certificate will automatically be issued with your policy documents).

Name of Certificate Holder	Is the Certificate Holder an Organization or an Individual?	Complete Address of Certificate Holder

Section V: WARRANTY QUESTIONS

("You" means any individual proposed for this insurance including any current or past employee, independent contractor or additional insured on your behalf.)

Have you experienced any of the following? ☐ Yes ☐ No

- Within the last 10 years, have you ever had a state license, certification, registration or malpractice insurance revoked, suspended, refused, denied renewal, cancelled, placed on probation, voluntarily surrendered or is such pending?
- Within the last 10 years, has a claim or suit for alleged malpractice been brought against you or are you aware of any incident that might reasonably lead to such a claim or suit?
- Have you ever been convicted (as an adult) of a felony or is any such case pending?
- Within the last 10 years, have you had any complaints or charges brought against you by any licensing board or professional ethics body?

IMPORTANT: If any answer above is "Yes", please attach a detailed explanation including dates, names of parties involved, allegations, your written response to the allegations if applicable and a copy of any formal ruling or notice by any regulator, licensing body, professional ethics board or insurer.

Section VI: SIGNATURE SECTION

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT TO SIGN THIS APPLICATION ON THE APPLICANT'S BEHALF AND DECLARES THAT THE STATEMENTS CONTAINED IN THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION AND THE UNDEWRITING OF THIS INSURANCE ARE TRUE, ACCURATE AND NOT MISLEADING. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION AND ANY OTHER INFORMATION AND MATERIALS SUBMITTED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING OF THIS INSURANCE ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

THIS APPLICATION AND ALL INFORMATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY AS IT DEEMS NECESSARY REGARDING THE INFORMATION AND MATERIALS PROVIDED TO THE INSURER IN CONNECTION WITH THE UNDERWRITING AND ISSUANCE OF THE POLICY.

THE APPLICANT AGREES THAT IF THE INFORMATION PROVIDED IN THIS APPLICATION OR IN CONNECTION WITH THE UNDERWRITING OF THE POLICY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

I HAVE READ THE FOREGOING APPLICATION FOR INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO AND 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.

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 KANSAS APPLICANTS: 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 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 COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY OR WILLFULLY 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 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 KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND 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. (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signed*:_____ Date:_____

Print Name:_____ Title: _____

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa, please provide the Insurance Agent's name and signature only.

Agent's Signature*:_____

Agent's Printed Name:_____ Florida Agent's License Number:_____

Send completed and signed applications to Lockton Affinity at:

Lockton_Info@LocktonAffinity.com or

Lockton Affinity, LLC
PO Box 876114
Kansas City, MO 64187-6114

Questions?
Email: Lockton_Info@LocktonAffinity.com
Phone: (800) 253-5486