Professional Liability Insurance Application for Health or Fitness Businesses (Group)

Section I: APPLICANT INFORMATION

What is your business's primary Fitness occupation? (Find a complete list of occupations eligible for coverage at LocktonPersonalTrainingInsurance.com)

_____

(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.)

Is your business or any of its employees a member of any professional association related to your occupation? ☐ Yes ☐ No

If yes, provide Association Name: _____ Member Number: _____

Business Name: _____

If you are the sole owner of your business and have no employees, complete the application for Individual coverage, which can be downloaded at LocktonPersonalTrainingInsurance.com

Street Address (If you have multiple locations please list separately): _____

City: _____ State: _____ Zip: _____

Phone: _____ Business Website: _____

Contact Name: _____ Title: _____

Contact Email: _____

Is your business a: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Other (describe) _____

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

Has your group's gross annual revenue exceeded $1,500,000 during any of the past 3 years? ☐ Yes ☐ No
(Gross Revenue means all compensation for the delivery of professional services before expenses, taxes, or other business costs are deducted.)

If Yes, Annual Gross Revenue for the past 12 months: _____ Expected Annual Gross Revenue for the next 12 months: _____

Section II: OWNER and EMPLOYEE SECTION

List all owners, partners, principals, professional employees, independent contractors and students providing professional services on behalf of the firm in the table below. Please indicate their employment status, scheduled hours, professional occupation, years of experience and degrees held for each Owner (includes partners, officers, and directors), Employee, Independent Contractor and Student.

If additional space is required, please continue on a separate piece of paper.
***NOTE:** Independent Contractors will be listed as employees if proof of a current policy is not provided.

OWNER(S)						
NAME	**PERCENTAGE OF OWNERSHIP**	**SCHEDULED HOURS** Per/week*	**PROFESSIONAL OCCUPATION** (Refer to Eligible Covered Occupations list)	**# YEARS OF EXPERIENCE** in Occupation	**# YEARS OF EDUCATION**	**DEGREES**

EMPLOYEES						
NAME	**EMPLOYMENT STATUS** Owner(**O**), Employee(**E**), Independent Contractor(**IC**); Student (**S**)	**SCHEDULED HOURS** Per/week*	**PROFESSIONAL OCCUPATION** (Refer to Eligible Covered Occupations list)	**# YEARS OF EXPERIENCE in Occupation**	**# YEARS OF EDUCATION**	**DEGREES**

* **NOTE:** When totaling hours, account for all hours associated with your profession including (but not limited to) client contact, administration, management and other services.

Section III: PROFESSIONAL LIMITS AND COVERAGE

1. Select the limits you require:

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

2. If there are 3 or more individuals in your firm, you may select a deductible:

- ☐ $5,000
- ☐ $10,000
- ☐ $25,000*

**If you select $25,000, please provide financial statements as proof of ability to pay deductible.*

Is the business name indicated in Section I of this application, or any qualifying Predecessor Firm, listed as the Named Insured on another active claims made Professional Liability policy that provides coverage for the same occupation(s) as applied for here? ☐ Yes ☐ No

Would you like to purchase a policy which provides coverage for acts back to 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, endorsement listing your prior acts retroactive date or complete the following:

Current 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 include coverage on your insurance. Please describe the business relationship or insurable interest of the Additional Insured 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)

(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.

Additional Insured coverage for Groups is subject to an additional premium of 5% of the Policy's total premium or $250 for each additional insured, whichever is more.

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 / DATE

(APPLICATION MUST BE SIGNED BY AN OFFICER OR OWNER OF THE COMPANY)
I hereby declare that the preceding statements and particulars contained in this application are true and that I have not suppressed or misstated any material facts and I agree that this declaration shall be the basis of the contract between me and the underwriters. SIGNING THIS FORM OR SUBMISSION OF PAYMENT DOES NOT BIND THE APPLICANT OR UNDERWRITER TO COMPLETE THE INSURANCE. HOWEVER, IF COVERAGE IS BOUND, THIS APPLICATION BECOMES A PART OF THE POLICY.

PLEASE TAKE NOTICE THAT:

1. Lockton Affinity may receive compensation from an insurer or other intermediary as a result of the sale of insurance to you.
2. The compensation received by Lockton Affinity may differ depending on the product, insurer and/or other intermediary.
3. Lockton Affinity may receive additional compensation from the insurer and/or other intermediary based upon other factors, such as premium volume placed with a particular insurer or through a particular intermediary and loss or claims experience.

I request that my insurance become effective on: _____ / _____ / _____
(Effective date may not be earlier than the date the application is received by the administrator and not more than 90 days from the date of this application.)

Signature _____ **Date** _____ / _____ / _____

Title _____

Send completed and signed application 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

This Professional Liability Insurance program has been organized as a purchasing group (National Professional Purchasing Group Association, Inc.), pursuant to legislation enacted by the U.S. Congress as the Federal Liability Risk Retention Act of 1986. You automatically become a member of the purchasing group once your completed application has been approved and your premium has been received.