



Professional Liability Application for Physical, Occupational, Speech Therapy

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; if the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

Tax ID: -

1.2 Mailing Address: _____

1.3 Location Address(es): _____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____) _____ Fax (_____) _____

Email: - _____

Website: - _____

1.6 Person to contact for Survey: Name: _____ Title: _____

Email: _____ Telephone Number: _____

1.7 Year entity established:

1.8 The Applicant is (Please check and complete A) or B) below:

A. The **APPLICANT** is an: INDIVIDUAL Employee Student Sole Practitioner

B. The **APPLICANT** is a: Sole Proprietorship Partnership Corporation Limited Liability

Other –Please Describe _____

1.9 Entity is: For Profit Non-Profit

Please describe source of funds:

1.10 Proposed Effective Date: _____

1.11 Requested Limits of Liability (if available): \$ _____ /\$ _____

If General Liability coverage also desired: \$ _____ /\$ _____

1.12 Annual Gross Receipts: Estimated next twelve months - \$ _____

Last twelve months - \$ _____

1.13 Annual Remuneration: Estimated next twelve months - \$ _____

Last twelve months - \$ _____

1.14 Total Premises Square Footage Occupied By Applicant: _____

If any services are provided away from insured's premises, please describe: _____

Are any services provided at the premises of a hospital, nursing home or similar healthcare inpatient facility?

Yes No

If **YES**, please give detailed description, and attach copy of contract if applicable.

1.15 Number of estimated client contacts: Next (12) months: _____

Last (12) months: _____

1.15 List all memberships in professional organizations: _____

PART II. EXPOSURES

b) over the age of 18 ? _____%

2.8 Approximately what percentage of applicant's practice is associated with sports injuries? _____%
Has applicant treated any professional or collegiate athletes? Yes No
If YES, how many in the past year? _____

2.9 Does applicant enter into contractual agreements relating to professional services? Yes No
If YES, please enclose copies of all such contracts, or specimen if all are the same.

2.10 Are any tests conducted / results interpreted or diagnosed by applicant? Yes No
If YES, please describe including who the results are sent to and on whose letterhead results are shown

2.11 **Unless otherwise noted hereunder, applicant warrants that:**

- a) Applicant does not sell, rent or otherwise distribute any products; if yes, does applicant carry General Liability insurance including Products?
- b) Applicant is not licensed, registered or certified to provide any other professional services except as stated in this application;
- c) Applicant is not a proprietor, superintendent, officer, director, stockholder or member of the board of directors, trustees or governors of any business enterprise, except as previously stated;
- d) Applicant does not advertise its professional services in any manner other than listing in the telephone directory; if so, attach copy of advertising.
- e) Neither applicant nor any of applicant's employees have:
 - i) ever been the subject of disciplinary or investigative proceedings or been reprimanded by governmental or administrative agency, hospital or professional association;
 - ii) ever been convicted of violation of any law or ordinance other than a traffic offense;
 - iii) ever had any state professional license, certificate or registration refused, suspended, revoked, renewal refuse or accepted only on special terms or has ever voluntarily surrendered same;
 - iv) ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance.
- f) Applicant does not have any other premises or operations exposures not stated in this application.

Explain Here **Exceptions**, if any, to above: _____

PART III. HISTORY

3.1 List prior professional liability insurers for the past five years, starting with the most recent year.
If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____

4. _____

5. _____

If claims-made, what is the most recent retroactive date? _____

3.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

3.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?
 Yes No

If YES, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary). _____

3.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?
 Yes No

If YES, please describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC. any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE

Date

Title

Applicant