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# Allied Health Care Professional and General Liability Product

THIS IS AN APPLICATION FOR A CLAIMS MADE (PROFESSIONAL) AND OCCURRENCE (GENERAL LIABILITY) POLICY. PLEASE READ YOUR POLICY CAREFULLY. DEFENSE COSTS SHALL BE APPLIED AGAINST THE DEDUCTIBLE.

## SECTION I. PROFESSIONAL LIABILITY UNDERWRITING INFORMATION

Applicant's name (include DBA name): \_\_\_\_\_

Location address: \_\_\_\_\_  Same as mailing address

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Web address: \_\_\_\_\_ E-mail address of primary contact: \_\_\_\_\_

Number of locations \_\_\_\_\_ Percent of services rendered outside the U.S., if any \_\_\_\_\_ % Annual revenue \_\_\_\_\_

Type of professional (i.e. massage therapist, mental health counselor, physical therapist, etc.)	Employees/Owners/ Partners/Self Employed		Independent Contractors (even if coverage is not desired for them)	
	Full Time	Part Time	Full Time	Part Time
1.				
2.				
3.				
4.				
5.				

**Independent contractor** means an individual who performs professional services for others and receives an IRS Form 1099 for compensation paid.

**Part time** means less than 1,000 hours worked per year.

1. Provide a detailed description of the nature of applicant's operation and services provided:

\_\_\_\_\_

2. Is the applicant seeking coverage for independent contractors?  Yes  No

a. Does the applicant verify that all independent contractors working on their behalf maintain professional liability?  Yes  No

3. Has any professional(s) seeking coverage been providing their services less than three years?  Yes  No

If "Yes," detail experience and qualifications: \_\_\_\_\_

\_\_\_\_\_

4. Do all professionals listed above, for whom coverage is sought, have a current, unrestricted professional license or its equivalent as required under federal or state law and/or the rules and regulations of the profession?  N/A  Yes  No

5. List professional license(s) and degree(s) or equivalents held by each professional listed above:

\_\_\_\_\_

6. Is the applicant controlled, owned, affiliated or associated with any firm, corporation or company not identified in this application?  Yes  No

If "Yes," please provide details: \_\_\_\_\_

7. Does the applicant have any subsidiaries for which coverage is sought?  Yes  No

If "Yes," please provide the name, percentage owned and professional classification of each subsidiary and include them in the list of professions above: \_\_\_\_\_

8. Percentage of services provided to minors \_\_\_\_\_ %

a. Are the parents or guardian present for these services?  Yes  No

9. Do any clients receive overnight or 24-hour care? (This would not include shift work involving service by more than one caregiver over that period of time)  Yes  No

10. Do any clients receive live-in care where the caregiver lives with the client?  Yes  No

11. What percent of the applicant's total operations involve 24-hour or overnight services through shift work (more than one caregiver over that period of time)? \_\_\_\_\_ %

12. Do any professionals for whom coverage is sought provide, practice, perform, administer or assist in any of the following now or expect to in the next 12 months:
- a. Surgery or surgical procedures including pre-operative and post operative procedures?  Yes  No
  - b. Injections of any kind?  Yes  No
  - c. Diagnosing conditions, disorders or diseases in patients?  Yes  No
  - d. Services as a physician, surgeon, nurse, anesthetist, anesthesiologist, psychiatrist, chiropractor, acupuncturist, pharmacist or dentist?  Yes  No
  - e. Designing, testing, selling, distributing or manufacturing products of any kind including vitamins, minerals, herbal, medicinal or nutritional supplements?  Yes  No
  - f. More than 25% of services involving the transportation of clients/patients?  Yes  No
  - g. Prescribing, monitoring or dispensing medication, equipment, or devices?  Yes  No
  - h. Provide professional services within any prison/correctional facility or for any probation or prison release program?  Yes  No
  - i. Hospice care?  Yes  No
  - j. Medical health care services (including but not limited to monitoring blood pressure, changing dressings, monitoring respiration rates)?  Yes  No
  - k. Provide more than 10% of services within a nursing home(s), or hospital?  Yes  No
  - l. Does the applicant provide any bathing and/or hygiene services?  Yes  No
- If "Yes" to any of the above, describe service(s) provided and percentage of patients/clients receiving each service(s):
- \_\_\_\_\_
- \_\_\_\_\_

13. Are criminal background checks and license verifications conducted for all professionals?  Yes  No
14. Does the applicant obtain a written informed consent from parents/guardians of minors receiving services?  In all cases  Sometimes  Never
15. List additional insured(s) required by contract to be included for professional liability coverage:

Name	Address	Relationship to Applicant

**Attach a statement of details for all "Yes" answers to the following questions:**

16. a. Has the applicant or any professional listed above had a professional license or its equivalent denied, revoked, restricted, suspended; been fined or disciplined in any way or been the subject of any investigation by any authority for any reason, including but not limited to allegations of sexual abuse?  Yes  No
- b. Are any such actions pending as of the date of this application?  Yes  No
17. Has the applicant initiated litigation against any patients or clients in the past five years?  Yes  No  
(if "Yes," provide names, dates, status of litigation and demand amount)
18. In the past five years, has any claim been made or suit brought against the applicant, its predecessor(s) in business or any of its present or former owners, partners, officers, directors, employees or independent contractors?  Yes  No
19. Is the applicant or any person proposed for this insurance aware of any circumstance, allegation, contention or incident which may result in a claim being made against the applicant or any person proposed for this insurance?  Yes  No
20. Has any policy of professional liability insurance ever been cancelled or non-renewed by an insurance carrier?  Yes  No  
(Not applicable in MO.) If "Yes," provide details \_\_\_\_\_
21. a. Does the applicant currently have professional liability insurance in force?  Yes  No
- b. Does the applicant currently have general liability insurance in force?  Yes  No
- If "Yes," specify:

Name of Professional Carrier	Limit	Retroactive Date (if any)	Deductible	Annual Premium	Policy Period	Claims Made (C) or Occurrence (O)
Name of General Liability Carrier	Limit	Retroactive Date (if any)	Deductible	Annual Premium	Policy Period	Claims Made (C) or Occurrence (O)

- c. Number of years continuous, uninterrupted insurance coverage? Professional liability: \_\_\_\_\_ General liability: \_\_\_\_\_
22. Does applicant agree to maintain commercial general liability insurance?  N/A  Yes  No
- If "No," explain: \_\_\_\_\_

**SECTION II. GENERAL LIABILITY UNDERWRITING INFORMATION** (complete only if seeking this coverage)

1. Any general liability claims against applicant (paid, reserved or pending) in the past five years?  Yes  No

If "Yes," please provide details: \_\_\_\_\_

2. Additional insured(s) to be included for general liability coverage:

Name	Address	Relationship to Applicant

3. Has any general liability policy been cancelled or non-renewed by an insurance carrier? (Not applicable in MO.)  Yes  No

If "Yes," provide details: \_\_\_\_\_

4. Is the applicant the owner of the insured location?  Yes  No

If "Yes," list all tenants of the building and the area of the portion occupied (if there are apartments, please indicate number of units)

Tenant	Building area or number of apartment units

**SECTION III: PROPERTY SECTION** (complete only if seeking this coverage)

1. Construction:  Frame  Joisted masonry  Non-combustible  Masonry non-combustible  
 Modified fire-resistive  Fire-resistive  Other \_\_\_\_\_

2. Protection class: \_\_\_\_\_

3. Requested cause of loss:  Basic  Special

4. Requested valuation:  Replacement cost  Actual cash value

5. Deductible:  \$1,000  \$2,500  \$5,000

6. Coinsurance:  80%  90%  100%

7. Business personal property limit \$ \_\_\_\_\_

8. Business income with extra expense limit \$ \_\_\_\_\_

9. What year was the building constructed? \_\_\_\_\_

10. What is the square footage of the entire structure? \_\_\_\_\_ sq. ft.

11. What is the square footage of the portion occupied by the applicant? \_\_\_\_\_ sq. ft.

12. Is the building fully protected by an operational sprinkler system covering 100% of the premises?  Yes  No

13. Age of roof \_\_\_\_\_ years

14. Roof type:  Flat  Wood shake  Shingle  Metal  Tile  Slate  Other \_\_\_\_\_

15. What Protection devices do you have on the premises?  Burglar Alarm  Fire Alarm  Central station  Local

16. Do you have Functional & Operating Smoke detectors?  Yes  No

17. List your loss information for the past three years: \_\_\_\_\_

**Property Coverages**  None, or provide detail below:

Year	Incurred	Status	Description of loss
	\$	<input type="checkbox"/> Open <input type="checkbox"/> Closed	
	\$	<input type="checkbox"/> Open <input type="checkbox"/> Closed	
	\$	<input type="checkbox"/> Open <input type="checkbox"/> Closed	

18. Has your insurance coverage been canceled or non-renewed within the last three years? (Not applicable in MO.)  Yes  No

19. Have you gone bankrupt within the past three years?  Yes  No

20. For any building built prior to 1978, do any lack knob-and-tube or aluminum wiring on premises?  Yes  No

21. For any building built prior to 1978, is 100% of the wiring on functioning and operational circuit breakers?  Yes  No

**SECTION IV: AUTO LIABILITY COVERAGE FOR HIRED OR NON-OWNED AUTOS** (complete only if seeking this coverage)

22. Does organization have a motor vehicle liability insurance policy in place?  Yes  No
23. Does organization own any motor vehicles or lease any motor vehicles on a long-term basis (greater than 30 days)?  Yes  No
24. Does organization use hired or non-owned vehicles with passenger capacities exceeding 15 passengers?  Yes  No
25. Does organization use hired or non-owned vehicles for emergency medical transportation or emergency medical services?  Yes  No
26. Does organization transport non-ambulatory persons?  Yes  No
27. Does organization require evidence of insurance from employees, independent contractors and volunteers?  Yes  No
28. Does organization require a minimum of \$100,000 combined single limit or \$100,000/\$300,000/\$50,000 personal auto liability limits from employees, independent contractors and volunteers?  Yes  No
29. Number of drivers: \_\_\_\_\_
30. Average driving frequency per week by drivers:  Once  2–3 times  Daily

**SECTION V: REQUIRED INFORMATION**

**A. USLI application**

**B. Supplemental application (for select classes)**

**FRAUD STATEMENTS**

**Alabama, Arkansas, District of Columbia, New Mexico, Rhode Island and West Virginia:** 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.

**California:** For your protection California law requires the following to appear on this application. Fraud Statement: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Fraud Statement:** 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.

**Florida Fraud Statement:** 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.

**Kansas Fraud Statement:** 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; or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of a crime and may be subject to fines and confinement in prison.

**Maine Fraud Statement:** 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

**Maryland Fraud Statement:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

**New Jersey Fraud Statement:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

**Oklahoma Fraud Statement:** 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.

**Oregon Fraud Statement:** Notice to Oregon applicants: Any person who, with intent to defraud or knowing that he is facilitation a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**Kentucky and Pennsylvania Fraud Statement:** 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.

**Tennessee, Virginia and Washington Fraud Statement:** 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 and denial of insurance benefits.

**Fraud Statement (All Other States):** 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 may be guilty of a crime and may be subject to fines and confinement in prison.

**STATE NOTICES**

**Arizona Notice:** Misrepresentations, omissions, concealment of facts and incorrect statements shall prevent recovery under the policy only if the misrepresentations, omissions, concealment of facts or incorrect statements are; fraudulent or material either to the acceptance of the risk, or to the hazard assumed by the insurer or the insurer in good faith would either not have issued the policy, or would not have issued a 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 insurer as required either by the application for the policy or otherwise.

**Florida Surplus Lines Notice:** (Applies only if policy is non-admitted) You are agreeing to place coverage in the surplus lines market. Superior coverage may be available in the admitted market and at a lesser cost. Persons insured by surplus lines carriers are not protected under the Florida Insurance Guaranty Act with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

**Florida and Illinois Punitive Damage Notice:** I understand that there is no coverage for punitive damages assessed directly against an insured under Florida and Illinois law. However, I also understand that punitive damages that are not assessed directly against an insured, also known as "vicariously assessed punitive damages", are insurable under Florida and Illinois law. Therefore, if any Policy is issued to the Applicant as a result of this Application and such Policy provides coverage for punitive damages, I understand and acknowledge that the coverage for Claims brought in the State of Florida and Illinois is limited to "vicariously assessed punitive damages" and that there is no coverage for directly assessed punitive damages.

**Maine Notice:** The insurer is not permitted to withdraw any binder once issued, but a prospective notice of cancellation may be sent and coverage denied for fraud or material misrepresentation in obtaining coverage. A policy may not be unilaterally rescinded or voided.

**New York Disclosure Notice:** This policy is written on a claims made basis and shall provide no coverage for claims arising out of incidents, occurrences or alleged Wrongful Acts or Wrongful Employment Acts that took place prior to retroactive date, if any, stated on the declarations. This policy shall cover only those claims made against an insured while the policy remains in effect for incidents reported during the Policy Period or any subsequent renewal of this Policy or any extended reporting period and all coverage under the policy ceases upon termination of the policy except for the automatic extended reporting period coverage unless the insured purchases additional extended reporting period coverage. The policy includes an automatic 60 day extended claims reporting period following the termination of this policy. The Insured may purchase for an additional premium an additional extended reporting period of 12 months, 24 months or 36 months following the termination of this policy. Potential coverage gaps may arise upon the expiration for this extended reporting period. During the first several years of a claims made relationship, claims-made rates are comparatively lower than occurrence rates. The insured can expect substantial annual premium increases independent overall rate increases until the claims-made relationship has matured.

**Ohio Representation Statement:** By acceptance of this policy, the Insured agrees the statements in the application (new or renewal) submitted to the company are true and correct. It is understood and agreed that, to the extent permitted by law, the Company reserves the right to rescind this policy, or any coverage provided herein, for material misrepresentations made by the Insured. It is understood and agreed that the statements made in the insurance applications are incorporated into, and shall form part of, this policy. THE INSURED UNDERSTANDS AND AGREES THAT ANY MATERIAL MISREPRESENTATION OR OMISSION ON THIS APPLICATION WILL ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY THE RIGHT TO RESCIND IT.

**Utah Punitive Damages Notice:** I understand that Punitive Damages are not insurable in the state of Utah. There will be no coverage afforded for Punitive Damages for any Claim brought in the State of Utah. Any coverage for Punitive Damages will only apply if a Claim is filed in a state which allows punitive or exemplary damages to be insurable. This may apply if a Claim is brought in another state by a subsidiary or additional location(s) of the Named Insured, outside the state of Utah, for which coverage is sought under the same policy

**Missouri and Rhode Island Disclosure Notice:** I understand and acknowledge that if a \$100,000 or \$250,000 Limit of Liability is chosen or if the Insured Organization has more than 200 employees, that Defense Costs are a part of the Limit of Liability. This means that Defense Costs will reduce my limits of insurance and may exhaust them completely and should that occur, I shall be liable for any further legal Defense Costs and Damages. Defense Costs are as defined in Section III. I also understand that the Limit of Liability for the Extended Reporting Period, if applicable, shall be a part of and not in addition to the limit specified in the Policy Declarations.

**Virginia Notice:** This Policy is written on a claims-made basis. Please read the policy carefully to understand your coverage. You have an option to purchase a separate limit of liability for the extended reporting period. If you do not elect this option, the limit of liability for the extended reporting period shall be part of the and not in addition to limit specified in the declarations. If you have any questions regarding the cost of an extended reporting period, please contact your insurance company or your insurance agent. Statements in the application shall be deemed the insured's representations. A statement made in the application or in any affidavit made before or after a loss under the policy will not be deemed material or invalidate coverage unless it is clearly proven that such statement was material to the risk when assumed and was untrue.

If your state requires that we have information regarding your Authorized Retail Agent or Broker, please provide below.

Retail agency name: \_\_\_\_\_ License #: \_\_\_\_\_

Agent's signature: \_\_\_\_\_ Main agency phone number: \_\_\_\_\_

(Required in New Hampshire)

Agency mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The signer of this application acknowledges and understands that the information provided in this Application is material to the Insurer's decision to provide the requested insurance and is relied on by the Insurer in providing such insurance. The signer of this application represents that the information provided in this Application is true and correct in all matters. The signer of this Application further represents that any changes in matters inquired about in this Application occurring prior to the effective date of coverage, which render the information provided herein untrue, incorrect or inaccurate in any way will be reported to the Insurer immediately in writing. The Insurer reserves the right to modify or withdraw any quote or binder issued if such changes are material to the insurability or premium charged, based on the Insurer's underwriting guides. The Insurer is hereby authorized, but not required, to make any investigation and inquiry in connection with the information, statements and disclosures provided in this Application. The decision of the Insurer not to make or to limit any investigation or inquiry shall not be deemed a waiver of any rights by the Insurer and shall not estop the Insurer from relying on any statement in this Application in the event the Policy is issued. It is agreed that this Application shall be the basis of the contract should a Policy be issued and it will be attached and become a part of the Policy.

**New York Fraud Statement:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant's signature: \_\_\_\_\_ Title: \_\_\_\_\_

President, Chairperson of the Board, Managing Member, or Executive Director

Date: \_\_\_\_\_



## Privacy Notice At Collection

We may need to collect certain personal information to provide you with our services and products. For information on how we store, use and protect personal information, please see our Privacy Policy accessible on our website, <https://www.usli.com/privacy-policy/>.