

Physical Therapists and Related Occupations Application

Darwin National Assurance Company Main Administrative Office: Corporate Office:
9 Farm Springs Road 1807 North Market Street
Farmington, CT 06070 Wilmington, DE 19802

Offered through the Professional Counselors Purchasing Group, Inc.

NOTICE: THIS IS AN APPLICATION FOR PROFESSIONAL AND PREMISES LIABILITY INSURANCE. SUBJECT TO ITS TERMS, THIS POLICY PROVIDES COVERAGE FOR CLAIMS ARISING FROM WRONGFUL ACTS OR OCCURRENCES THAT TAKE PLACE DURING THE POLICY PERIOD.

DEFENSE EXPENSES PAYABLE UNDER THE POLICY ARE PAYABLE IN ADDITION TO THE LIMITS OF LIABILITY. A SMALLER LIMIT OF LIABILITY WILL APPLY TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT, OR TO ANY SUPPLEMENTAL PAYMENT.

If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

- o Attach a separate sheet of paper if more space is needed to answer any question.
- o Attach copy of current state license or certification
- o Attach promotional materials used in your practice
- o Attach any claims history for professional or premises liability

Are You:

- Self-Employed** (Self-Employed means an individual working for themselves or with others as partners or as owners of a group or entity.)
- Employee** (Employee means a person who has been hired to perform services, and who has an assigned work schedule and appears on a payroll with applicable federal, state and local taxes withheld, e.g. W-2.)
- Student**

(1) General Information

- (a) Applicant's Name: _____
- (b) Address: _____
City: _____ State: _____ ZIP: _____
- (c) E-mail address: _____ Telephone number _____
- (d) License/Certification # (if applicable) _____
- (e) If You answered **Self-Employed**, please provide the following additional information:

(i) Are You a:

- | | | |
|----------------------------------------|-----------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> PC | <input type="checkbox"/> Sole Proprietor/Individual | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> LLP | <input type="checkbox"/> LLC | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Other | |

If Other, please describe: _____

Name of Entity if different than Name of Applicant:

Key Contact Name: _____ Title: _____

(ii) Are You seeking Premises Liability coverage?

- Yes No

- (iii) Are You required by contract to include an individual or entity as an additional insured under the policy for professional services you or any of your employees provide?

(Additional Insured coverage protects a third party You provide services for against claims arising out of wrongful acts. You should only purchase this coverage if you are required to.)

Yes No

- (iv) Are You seeking coverage for any subsidiary? Please note that coverage for such subsidiaries is not automatically available; the terms and conditions of the policy, if issued, will determined actual coverage.

Yes No

Name/Address	Relation to applicants	Description of Ops	Tax Status	Percent Owned

- (f) If You answered **Employee**, please provide the following additional information:

Employer Name: _____

Employer City, State: _____

(2) Requested Effective Date: _____

(3) Description of Practice

- (a) Eligible Occupations - Please check all Specialties performed in Your practice:

- a. Athletic Trainer
- b. Bodywork Counselor
- c. Chiropractic Assistant
- d. Corrective Therapist
- e. Exercise Physiologist
- f. Fitness Instructor
- g. Kinesiologist
- h. Kinesiotherapist
- i. Massage Therapist
- j. Occupational Therapist
- k. Occupational Therapist Assistant
- l. Orthopedic Assistant
- m. Orthopedic Technician
- n. Pedorthist
- o. Personal Trainer
- p. Physical Therapist
- q. Physical Therapist Aide
- r. Physical Therapist Assistant
- s. Physiotherapist
- t. Recreational Therapist
- u. Rehabilitation Assistant
- v. Rehabilitation Counselor
- w. Rehabilitation Technician
- x. Rehabilitation Therapist
- y. Sports Medicine Instructor
- z. Sports Medicine Therapist

- (c) Have You or any of your employees or independent contractors ever engaged in any sexual misconduct with any of Your current or former patients, or any current or former patient's spouse, or any person with a direct relationship to a current or former patient or any current or former patient's spouse or any person with a direct relationship to the patient or former patient (for example, a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?

(Sexual misconduct means any actual or alleged erotic physical contact or attempt, threat or proposal thereof whether consensual or not.)

Yes No

If You answered "Yes" to the questions (6)(a), (6)(b) or (6)(c) above, provide complete details on a separate page and attach it to the application.

MISSOURI APPLICANTS DO NOT ANSWER QUESTION (7).

- (7) During the past five years, has Your Professional Liability coverage been cancelled or non-renewed for a reason other than the insurer withdrawing from a state or no longer providing coverage?

Yes No

If You answered "Yes" to the question above, provide complete details on a separate page and attach it to the application.

SIGNATURES, NOTICES AND REPRESENTATIONS

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, PARTNER, DIRECTOR OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY THE INSURER IN WRITING OF SUCH CHANGES. THE INSURER RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS OR ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF AND AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ARE TRUE AND ACCURATE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE INSURER, ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE INSURER.

NOTICE TO APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, 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 ACT, WHICH IS A CRIME ANY MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

I UNDERSTAND THAT IT IS MY OBLIGATION TO MAINTAIN ANY LICENSE REQUIRED IN THE JURISDICTION(S) IN WHICH I PRACTICE.

Date: _____

Signature: _____

Title: _____

Print Name: _____

Signature of Authorized Representative of the American Professional Agency, Inc.:

Please make checks payable and mail to: American Professional Agency, Inc.

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
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