PHYSICAL THERAPISTS AND RELATED OCCUPATIONS APPLICATION

☐ **Darwin National Assurance Company**

☐ **Darwin Select Insurance Company**

Main Administrative Office:
9 Farm Springs Road
Farmington, CT 06070

Corporate Office:
1807 North Market Street
Wilmington, DE 19802

Offered through the Professional Counselors Purchasing Group, Inc.

NOTICE: THIS IS AN APPLICATION FOR PROFESSIONAL AND PREMISES LIABILTY 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 MAY BE PAYABLE IN ADDITION TO THE LIMITS OF LIABILITY, OR MAY REDUCE AND MAY EXHAUST THE APPLICABLE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS, DEPENDING ON THE COVERAGE WHICH IS APPLICABLE. 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.

- Attach a separate sheet of paper if more space is needed to answer any question.
- Attach copy of current state license or certification.
- Attach promotional materials used in your practice.
- 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:

☐ PC ☐ Sole Proprietor/Individual ☐ Partnership
☐ LLP ☐ LLC ☐ Corporation
☐ Joint Venture ☐ 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 determine 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

(b) List Your name and qualifications. In addition, list the names and qualifications of each individual who performs services for You or on Your behalf, except clerical services. If additional space is required, please use a separate sheet of paper.

Name	Degree		Specialty/ Specialties (List all specialties performed)	Number of hours of practice each week	License or Certification				Employment Status (Indicate Partner or Owner, Employee (W-2), Independent Contractor (Form 1099), or Student.)
	Degree Title	Field Of Study			State	Title	Number	Expiration Date	

NOTE: Independent Contractors (Form 1099) are not covered under this Policy, unless specifically included by Endorsement. You will, however, be covered for their acts, subject to the terms and conditions of the Policy. If You have listed Independent Contractors above, more information may be requested from the Insurer, as well as additional premium, to include them in the coverage available under the Policy.

(4) Do You and Your employees, or independent contractors, have a degree, certification or training from an accredited institution, association, licensing board, or regulatory agency responsible for maintaining the standards of the speciality/specialties selected?

☐ Yes ☐ No

(5) Do You or any of Your employees or independent contractors practice any of the specialties selected at any jail, prison, correctional facility or any similar type of facility?
☐ Yes ☐ No

(6) Suits, Claims or Potential Claims

(a) Has any claim or lawsuit for malpractice ever been brought against You or any of Your employees or independent contractors?
☐ Yes ☐ No

(b) Have You or any of Your employees or independent contractors ever been the subject of complaints, charges, or disciplinary action against You for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of Your profession?
☐ Yes ☐ No

(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 AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND WEST VIRGINIA 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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 KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA AND NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

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 INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

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.

NOTICE TO NEW YORK 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 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.

NOTICE TO OHIO APPLICANTS: 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.

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.

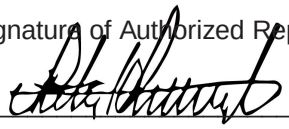
NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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.:



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Save form first on your computer before submitting.

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

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694
www.americanprofessional.com

American Professional Agency, Inc.

CORPORATE COVERAGE

Please note that if you are applying for corporate coverage, the following must be included when submitting your application:

- a letter describing all services provided (included any brochures if available)
- a copy your articles of incorporation
- a listing of owners and/or partners indicating the percentage owned by each

IMPORTANT SURCHARGE INFORMATION
Allied World Insurance Company

NOTICE TO FLORIDA RESIDENTS:

The Florida Insurance Guaranty Association requires insurance companies to charge all policies written for its residents a surcharge of 1%. Please include this additional premium when remitting your premium.

NOTICE TO KENTUCKY RESIDENTS:

Kentucky law requires insurance companies to charge all policies written for its residents a surcharge of 1.8%. Depending on your profession, we may be required to assess your policy with a municipality tax which is based on the location of your residence. Please include this additional premium when remitting your premium.

NOTICE TO MAINE RESIDENTS:

The Rural Medical Access Program requires insurance companies to charge physicians, hospitals, and physicians' employers who are insured for professional liability through a licensed insurer to pay the assessment of .4% to the insurer upon the insurers' premium billing. This charge applies to policyholders who are Psychiatrists, Psychiatric NPs, Physician Assistants, Neurologists, Nurse Practitioners, APRNs, and CNSs with prescriptive authority.

NOTICE TO NEW JERSEY RESIDENTS:

The New Jersey Property and Liability Insurance Guaranty Association requires insurance companies to charge all policies written for its residents a surcharge of .3%. Please include this additional premium when remitting your premium.

NOTICE TO WEST VIRGINIA RESIDENTS:

West Virginia law requires insurance companies to charge all policies written for its residents a surcharge of .55%. Please include this additional premium when remitting your premium.