FOR OFFICE USE ONLY
PREMIUM:
RATED BY:
EFFECTIVE DATE:
RETRO DATE:
REFUND AMOUNT DUE:

Allied World Insurance Company ("Insurer")

Return and make checks payable to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

APPLICATION FOR ALLIED HEALTH PROFESSIONALS' PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants:
License # L045052 issued to American Professional Agency, Inc.

Notice to Iowa Applicants:
License # 3000928232 issued to American Professional Agency, Inc.

Notice to California Applicants:
License # 0555091 issued to American Professional Agency, Inc.

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION V. (C), "MAXIMUM LIMIT OF LIABILITY - SEXUAL MISCONDUCT" IN THE POLICY).

- This Application must be completed in full, including all required attachments. Write "None" if that applies.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant's needs.

PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. (a) Name of Agent: _____ License No.:_____
   (b) Name of Applicant: _____ License No.:_____
   Date of Birth: _____ E-mail address: _____

   Office Telephone: ( ) _____ Home Telephone: ( ) _____

   Fax Number :( ) _____

(c) Coverage desired (check one):

☐Individual ☐Partnership ☐Professional Corporation (Incorporated as a P.C. or P.A.) ☐LLC/LLP
☐General Business Corporation: ☐Profit ☐Nonprofit ☐Other (Please explain) _____

(If you are unsure of your corporate status, please check your Articles of Incorporation or other business documents.)

If you have checked anything other than "Individual" above, the following MUST BE INCLUDED: (1) a copy of articles of incorporation; (2) a letter describing all services provided; (3) any brochures if available; and (4) a listing of owners and/or partners, indicating the percentage of the business owned by each.

(c) Employment status: ☐ Self-employed ☐ Employed ☐ New Graduate ☐ Student

II. APPLICANT INFORMATION

2. Mailing Address:_____

_____

(City) (County) (State) (Zip code)

III. PRACTICE CHARACTERISTICS

3. **Eligible Occupations: Please check all Specialties performed in your practice:**

☐Aerobic Instructor	☐Kinesiologist	☐Rehabilitation Assistant
☐Alexander Technique Instructor	☐Kinesiotherapist	☐Rehabilitation Counselor
☐Art Therapist	☐Lifestyle & Weight Management Consultant	☐Rehabilitation Engineer
☐Athletic Trainer	☐Massage Therapist	☐Rehabilitation Technician
☐Audiologist	☐Music Therapist	☐Rehabilitation Therapist
☐Bodywork Counselor	☐Nutritionist	☐Reiki Counselor
☐Certified Strength & Conditioning Specialist	☐Occupational Therapist	☐Rolfer
☐Chiropractic Assistant	☐Orthopedic Assistant	☐Somatic Movement Practitioner / Therapist
☐Clinical Exercise Specialist	☐Orthopedic Technician	☐Speech Hearing Therapist
☐Corrective Therapist	☐Pedorthist	☐Speech & Language Pathologist
☐Dance therapist	☐Personal Trainer	☐Speech Language Pathology Aide
☐Dietician	☐Physical Therapist	☐Speech Language Pathology Assistant
☐Ergonomist	☐Physical Therapist Aide	☐Sports Medicine Counselor
☐Exercise Physiologist	☐Physical Therapist Asst	☐Sports Medicine Instructor
☐Feldenkrais Therapist	☐Physiotherapist	☐Structural Integrator
☐Fitness Trainer	☐Pilate/Yoga Instructor	☐Tai Chi Instructor
☐Health Educator	☐Polarity Therapy Practitioner	☐Trager Practitioner
☐Health/Wellness Coach	☐Recreational Therapist	☐Other:_____

4. List your name and qualifications. In addition, list the names and qualifications of all your salaried (W2) employees, except clerical. If you are applying for a partnership policy, please list all partners as well. Please use a separate sheet of paper if additional space is required. Please include the premium charge indicated on the rate schedule for yourself and each employee and/or partner.

If additional space is required, please use a separate sheet of paper to submit a complete listing.

Name	All Degrees You Hold	Date Degree Received	Field of Study	Specialty/ Specialties	*Number of hours practice each week	License or Certification			
						First Year Licensed/Cert.	License State	License Number	Title

*You must include <u>all</u> hours you practice (privately and as an employee). If your total number of hours exceed 20, you do not qualify for the part-time rate.

5. Please list the number of your entire employed staff (except clerical) including yourself. _____
Note: Your staff is defined as your direct employees (for whom you file a W-2 form) and their names and credentials must be included with yours under Question 4. to correspond with the number listed here.

6. Is the applicant a member in good standing of any professional association? ☐ Yes ☐ No
(a) If so, state the organization and type of membership.
(i.e. Regular, Clinical, Associate, Student, etc.):_____

7. Are you engaged in self-employment, paid consultation (1099 form), private practice or volunteer work?
☐ Yes ☐ No

8. Are you employed (a W-2 form employee)? ☐ Yes ☐ No
If yes, on a full-time or part-time (20 hours or less) basis? ☐ Full-Time ☐ Part-Time
If yes, please complete the information below.

(a) Name of your employer:_____
(b) Address of your employer: _____

I understand that if I apply and qualify for the exclusively employed rate the policy will exclude coverage for private practice, self-employment consulting, volunteer work, or any work outside of the course and scope of your employment

9. Do you or any person named in Question 4. own, partly own, manage or exercise any form of fiduciary control over any business enterprise that provides allied health services? ☐ Yes ☐ No
If yes, please explain, and include the name of the business or enterprise:_____

10. (a) Does the Applicant use any Independent Contractors or Consultants (1099 form) whose services are in the allied health field and who you do billing for, share fees with or in any way derive income from the relationship?
☐ Yes ☐ No

(b) If yes, please list the name and professional credentials of each one.

NOTE: Independent Contractors or Consultants (1099 form) are not covered under this Policy, unless specifically included by Endorsement. **You will be covered for their acts subject to the terms of the policy, but the independent contractors or consultants listed will not be insureds under the policy. Additional information may be requested from the Insurer as well as additional premium to include them in the coverage available under the Policy.**

Name of Independent Contractor or Consultant	Degree	Field of Study	License or Certification	
			State	Title

If additional space is required, please use a separate sheet of paper to submit a complete listing.

11. Has any person or entity, based on a contractual obligation, requested that they be added to your policy as an Additional Insured? ☐ Yes ☐ No

(a) Name of proposed Additional Insured: _____

(b) Address of proposed Additional Insured: _____

(c) The Additional Insured is my:
☐Employer ☐Landlord ☐Professional Corporation ☐Other (Specify): _____

(d) The Additional Insured gives me the following form to file with the IRS:
☐W-2 form ☐ 1099 form ☐Other (Specify): _____

(e) Describe the relationship between you and the Proposed Additional Insured: _____

(f) Are you requesting that the person or entity named in 12(a) above be added as an Additional Insured in order to fulfill a contractual obligation? ☐ Yes ☐ No

If yes, provide full particulars: _____

12. Are you seeking coverage for any subsidiary? Please note that coverage for such subsidiaries is not automatically available; terms and conditions of the policy, if issued, will determine actual coverage. ☐ Yes ☐ No

Name/Address	Relation to applicant	Description of Ops	Tax Status	Percentage Owned

IV. GENERAL BUSINESS LIABILITY COVERAGE OPTION

13. (a) Do you wish to include General Business Liability Coverage? ☐Yes ☐No

V. PRIOR COVERAGE HISTORY

14. Please provide the following information for each person listed in Question 4 that has had Professional Liability Insurance, using a separate piece of paper if necessary.
If there is no insurance currently in force for any person listed in Question 4, please check here. ☐

	Effective Date – Termination Date	Carrier Name	Limits	Retention	Premium	Retro Date (Prior Acts Date)
Current Carrier			$	$	$	
Prior Carrier			$	$	$	
Prior Carrier			$	$	$	

(a) Number of years continuously insured with present and prior carriers: _____

(b) Type of policy: ☐Occurrence ☐Claims-Made

VI. REPRESENTATIONS

15. After inquiry* of each individual listed in Question 4:

***** "After inquiry" means that the Applicant has inquired of each person as to whether he/she has information pertinent to this question.
If you answer "Yes" to any question below, please include all documents pertinent to the situation you are describing.

(a) Is any person named in Question 4, including yourself, currently under investigation, indictment or notice of pending criminal charges of any kind or ever been convicted of a crime in any state or country? ☐Yes ☐No
If yes, please give full particulars in order for your Application to be considered. _____

_____

_____

(b) Has any person named in Question 4, including yourself, ever had any licensing board or professional ethics body require the surrender of a license or found any such person or you guilty of a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐Yes ☐No

If yes, please give full particulars and provide copies of charges, correspondence and any findings in order for your Application to be considered.

_____

_____

(c) Are there any complaints, charges or investigations pending against any person named in Question 4, including yourself, by a licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐Yes ☐No

If yes, please give full particulars and copies of charges, correspondence and any findings in order for your Application to be considered._____

_____

_____

NOTE: MISSOURI APPLICANTS DO NOT RESPOND TO QUESTION 15. (d)

(d) Has any person named in Question 4, including yourself, ever had any insurance company or Lloyd's decline, cancel, refuse to renew, or accept only on special terms any professional liability insurance? ☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered._____

_____

_____

(e) Has any professional liability claim or suit ever been made against any person named in Question 4, including yourself, their predecessors in business or against any past or present partner(s)? ☐Yes ☐No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your Application to be considered.

_____

_____

(f)Are there any circumstances, of which any person named in Question 4, including yourself, is aware of that may result in any complaint being made to a licensing board or governmental body or any professional liability claim or suit being made against any person named in Question 4, including yourself, their predecessors in business or against any past or present partner(s), including any loss of private or confidential information ☐Yes ☐No

If yes, please give full particulars in order for your Application to be considered._____

_____

_____

(g) Is any person named in Question 4, including yourself, engaged in or ever been 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 the current or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)? ☐Yes ☐No

(*"Sexual misconduct" means any actual or alleged erotic physical contact or attempt, threat or proposal thereof.)

If yes, please give full particulars in order for your Application to be considered.

_____

_____

VII. NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO ALABAMA 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 RESTITUTION, FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

NOTICE TO ARKANSAS 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 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."

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 HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OF BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

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 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 MAINE 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO MARYLAND APPLICANTS: "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."

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 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 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 (365:15-1-10, 36 §3613.1)."

NOTICE TO OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

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."

NOTICE TO RHODE ISLAND 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 OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO TENNESSEE 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 TEXAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

NOTICE TO VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

NOTICE TO VIRGINIA 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 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 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."

NOTICE TO ALL OTHER 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

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."

VIII. DECLARATION AND SIGNATURE

I understand that is it my obligation to maintain any license required in the jurisdictions in which I practice.

Date:_____ Signature:_____
(This application must be dated within 30 days of receipt) (APPLICANT / OWNER / PRESIDENT OF CORPORATION)

Title:_____

Application must be signed, dated, fully completed and accompanied by the premium to be considered.

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

Producer Signature:

Save form first on your computer before submitting.

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.