NAME: _____ DATE: _____

ACCOUNT: _____

POLICY #: _____

Please make checks payable to: American Professional Agency,

Dear Client:
This form will be replacing your renewal application. Please provide us with any changes that need to be made to your coverage and complete the required questions below. Sign and date this form and return it to us with your premium payment. If you have any questions, please call us at 1-800-421- 6694. **Failure to return the required items before the renewal date will cause this policy to lapse.**
If the bank returns your premium payment for uncollected funds, we will redeposit your payment, if possible. In instances where we must return your check to you, we will be assessing you a $20 service charge.

THIS SECTION MUST BE COMPLETED BY YOU **Please answer the following questions.**

1. At this time, do you or anyone listed on your policy have a pending claim, new claim, potential claim or licensing board complaint, or recently been found guilty of an ethics violation or professional misconduct, or been convicted of a crime? **(YES)____ (NO)____** If yes, please send complete details along with any pertinent papers regarding the situation. **Since your last renewal if a board complaint has been adjudicated, you must send us all documentation regarding the outcome.**
2. Is any person covered under this policy 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 patient or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)? **(YES)____ (NO)____**
3. **Please check if you are receiving the exclusively employed rate:** ☐ I understand that if I apply and qualify for the exclusively employed rate, the policy will exclude coverage for private practice, volunteering and independent contractual services.
4. Date of Birth:____/____/____

TO BE COMPLETED IF YOU HAVE ANY CHANGES **( ) There are no changes to my current coverage.**

1. Name:_____
2. Address:_____
3. E-mail address:_____ Phone #: _____
4. (a) Limits of Liability:_____ (b) Defense Reimbursement Limits:_____
5. Staff changes (staff listing must be included): If there has been any change in your staff (employees or independent contractors), using a separate piece of paper, please provide us with the names, degrees, fields of study, license (state & title) of all your staff and whether they are W2 employees or 1099 contractors. (*Please refer to the chart on reverse side to calculate premium due.*)
6. Credential changes: If you or any of your staff's credentials have changed (i.e. MSW to Ph.D.), please advise us.
7. Change to: ◯ Exclusively Employed ◯ Full-time ◯ Part-time The part-time discounted rate is available if your total working hours in **ALL** positions including W2 employment and volunteering does not exceed 20 hours. You DO NOT qualify, if you are incorporated, in a partnership, in a LLC, with any W2 form employees or if you use the services of more than 3 independent contractors. **Total number of hours per week**_____.
8. Type of Coverage _____.

NOTE: A new application will need to be completed if you are changing the Type of Coverage on your policy (i.e. from an individual to a corporation). An application is available by calling our office at 1-800-421-6694 or downloading one from our website at www.americanprofessional.com. These situations may be considered a new submission; therefore, a completed application is required

Date _____ Signature _____ Signature and Payment Required

PAYMENT OPTIONS: Please check the appropriate box for your payment option:

( ) I have enclosed my check payable to **AMERICAN PROFESSIONAL AGENCY, INC.** along with my renewal application.
( ) Upon review and acceptance of my renewal application, please set up an online payment at www.americanprofessional.com. I understand that you will send me an email at the **email address** indicated above with instruction needed to complete this task. No credit card information should be sent to this office.

Individual policy holders ONLY may renew online at www.americanprofessional.com

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.