LOCKTON AFFINITY Health

The following health care professionals must complete the Professional Liability Insurance Application for Individual Allied Health Care Professionals:

- Massage Therapist
- Pharmacist
- Pharmacy Assistant and Technician
- Physical Therapist

Instructions to complete and submit the application are listed below.

1. Fill out the PDF application electronically.

2. Applicants are allowed to print and sign or provide an electronic signature.

3. Email completed applications to **Lockton_Info@LocktonAffinity.com** or mail to **PO Box 410679, Kansas City, MO, 64141**.

4. Once received by Lockton Affinity, a link to submit payment will be sent to the email address provided on the application.

5. The insurance will be active as of 12:01 a.m. the next day after payment is received.

6. The Certificate of Insurance will be issued soon after. However, coverage is immediate after payment is received.

If you reside in the following states, you must contact a Lockton Affinity customer service representative at **(800) 253-5486** or **Lockton_Info@LocktonAffinity.com** for a state-specific application.

ME, NH, NC, PA, SD and VT

Professional Liability Insurance Application for Individual Allied Healthcare Professionals

LOCKTON AFFINITY Health

Section I: APPLICANT INFORMATION

What is your Allied Healthcare occupation? (Find a complete list of occupations eligible for coverage at LockonAffinityHealth.com)

_____

(Not all occupations qualify for coverage. You must hold a valid license or certificate if required by federal, state or local regulations for each occupation requested.)

Are you a member of any professional association related to your occupation? ☐ Yes ☐ No

If yes, provide Association name: _____ Member number: _____

Applicant Name (First/Last): _____

Business Name (optional): _____

If you are the sole owner of your business and have no employees, your business name will also be listed as a Named Insured on your policy. If you do not own 100% of your business or if you have employees or other associated individuals providing services on your behalf, please complete the Group Coverage application, which can be downloaded at LockonAffinityHealth.com.

Street Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Section II: EMPLOYMENT/OCCUPATION INFORMATION

How many years of relevant experience do you have? (Include any time you may have worked under supervision)

☐ Greater than 1 year, less than two years
☐ Greater than 2 years, less than three years
☐ Greater than 3 years

How many hours do you work per week? _____

Select your status: (If you are both employed and self-employed, please select self-employed)

☐ Employed (you provide services on behalf of an entity you do not own, and receive a W-2 form from your employer)
☐ Self-Employed Full-time (you provide services as an independent contractor, and pay self-employment taxes using a 1099 form)
☐ Self-Employed Part-time (less than 25 hours a week)
☐ Student - Anticipated Graduation Date: _____ / _____ / _____

Have you obtained secondary certification or licensure or had more than four hours of continuing education on risk management, ethics, or legal issues relevant to your profession within the past 12 months? You may be eligible for a discount. ☐ Yes ☐ No

If yes, list the Name of Organization _____
Date of Certification or Continuing Education _____(mm/dd/yyyy)

This policy does not provide coverage for the following exposures. Please review the list carefully.

- Professional services to residents in/on the premises of any long-term care facility, i.e. nursing home or residential care facility
- Youth-focused overnight professional programs such as Outward-Bound, boot camps, etc.
- Professional services to professional athletes whose annual income is $25,000 or greater
- Jobsite training or consulting that would normally be performed on a construction jobsite or in a manufacturing or factory setting by a safety inspector, safety trainer, or environmental inspector or consultant.

Do you provide ANY of the above services? ☐ Yes ☐ No

If yes, please contact Lockton Affinity at Lockton_Info@LocktonAffinity.com or (800) 253-5486.

Have you used or do you plan to use any life sustaining or critical life monitoring equipment or devices in your practice other than emergency defibrillation devices, i.e. an Automated External Defibrillator (AED)? This includes oxygen and other medical gases used in conjunction with respiratory therapy, dialysis or heart lung machines, SIDS monitors or any other life dependent monitors or equipment or devices that malfunction and could result in death or serious deterioration of a patient's health condition. ☐ Yes ☐ No

Section III: PROFESSIONAL LIMITS AND COVERAGE

Select the limits you require:

☐ $2,000,000 / $4,000,000
☐ $1,000,000 / $3,000,000
☐ $1,000,000 / $1,000,000
☐ $500,000 / $500,000

Are you listed as the Named Insured on another active Professional Liability policy that provides coverage for the same occupation and offers claims made coverage? ☐ Yes ☐ No

Would you like to purchase a policy that provides coverage for prior incidents by matching your current policy's Prior Acts/Retroactive date? ☐ Yes ☐ No

If "Yes" to both questions above, please provide a copy of your current Claims Made Declarations Page, an endorsement listing your prior acts retroactive date or complete the following:

Insurance Company Name: _____

Policy Expiration Date: _____(mm/dd/yyyy)

Policy Prior Acts/Retroactive Date: _____(mm/dd/yyyy)

If "No" to either of the above, the Policy Prior Acts/Retroactive Date will be the policy effective date.

**NOTE: You will need to provide Underwriters with a copy of your expiring policy to verify your current prior acts retroactive date should a claim be presented in the future under this program.*

Section IV: ADDITIONAL INSUREDS TO BE INSURED

Additional Insureds must have a valid insurable interest or a written requirement to be included on your insurance. Please describe the business relationship or insurable interest of the Additional Insureds using the list below*.

Name of Additional Insured	Is the Additional Insured an Organization or an Individual?	Complete Address of Additional Insured	Business Relationship/Insurable Interest: (enter the applicable number(s) from the list below or explain)

***For Business Relationship, choose from the following: (1)** Co-Owner Of Insured Premises **(2)** Grantor Of Franchise **(3)** Land Owner Lessor Of Leased Equipment Lessor of Premises **(4)** Managers of Premises used for providing Professional Services **(5)** Mortgagee, Assignee, Or Receiver **(6)** Owner Or Other Interests From Whom Land Has Been Leased **(7)** I am in a contractual agreement with the requested Additional Insured to name them as such **(8)** They are my employee or independent contractor **(9)** Other; please describe.

CERTIFICATE HOLDER
If you are required by contract to provide Proof of Coverage to a third party, provide the required information below. (A Proof of Coverage Certificate will automatically be issued with your policy documents).

Name of Certificate Holder	Is the Certificate Holder an Organization or an Individual?	Complete Address of Certificate Holder

Section V: WARRANTY QUESTIONS

("You" means any individual proposed for this insurance including any current or past employee, independent contractor or additional insured on your behalf.)
Have you experienced any of the following?

☐ Yes ☐ No

- Within the last 10 years, have you ever had a state license, certification, registration or malpractice insurance revoked, suspended, refused, denied renewal, cancelled, placed on probation, voluntarily surrendered or is such pending?
- Within the last 10 years, has a claim or suit for alleged malpractice been brought against you or are you aware of any incident that might reasonably lead to such a claim or suit?
- Have you ever been convicted (as an adult) of a felony or is any such case pending?
- Within the last 10 years, have you had any complaints or charges brought against you by any licensing board or professional ethics body?

IMPORTANT: If any answer above is "Yes", please attach a detailed explanation including dates, names of parties involved, allegations, your written response to the allegations if applicable and a copy of any formal ruling or notice by any regulator, licensing body, professional ethics board or insurer.

Section VI: SIGNATURE / DATE

I hereby declare that the preceding statements and particulars contained in this application are true and that I have not suppressed or misstated any material facts and I agree that this declaration shall be the basis of the contract between me and the underwriters. SIGNING THIS FORM OR SUBMISSION OF PAYMENT DOES NOT BIND THE APPLICANT OR UNDERWRITER TO COMPLETE THE INSURANCE. HOWEVER, IF COVERAGE IS BOUND, THIS APPLICATION BECOMES A PART OF THE POLICY.

PLEASE TAKE NOTICE THAT:

1. Lockton Affinity may receive compensation from an insurer or other intermediary as a result of the sale of insurance to you.
2. The compensation received by Lockton Affinity may differ depending on the product, insurer and/or other intermediary.
3. Lockton Affinity may receive additional compensation from the insurer and/or other intermediary based upon other factors, such as premium volume placed with a particular insurer or through a particular intermediary and loss or claims experience.

I request that my insurance become effective on: _____ / _____ / _____
(Effective date may not be earlier than the date the application is received by the administrator and not more than 90 days from the date of this application.)

Signature _____ **Date** _____ / _____ / _____

Send completed and signed applications to Lockton Affinity at:

LocktonAffinityHealth.com or

Lockton Affinity, LLC
PO Box 410679
Kansas City, MO 64141

Questions?
Email: Lockton_Info@LocktonAffinity.com
Phone: (800) 253-5486

This Professional Liability Insurance program has been organized as a purchasing group (National Professional Purchasing Group Association, Inc.), pursuant to legislation enacted by the U.S. Congress as the Federal Liability Risk Retention Act of 1986. You automatically become a member of the purchasing group once your completed application has been approved and your premium has been received.