Student Blanket Professional Liability Insurance Application

159 East County Line Road Hatboro, PA 19040-1218
Phone: 1-800-986-4627 Fax: 1-866-321-0905

_ _ _-_ _ WW9SBB

1. Application Information

PLEASE COMPLETE THE FOLLOWING:

1. Name of School: _____
2. Physical Address: _____
   City: _____ State: _____ Zip: _____
3. Mailing Address: _____
   City: _____ State: _____ Zip: _____
4. Person to contact at school:
   a. Name: _____
   b. Title: _____
   c. Department: _____
   d. Telephone: _____
   e. Fax: _____
   f. E-Mail: _____
5. Requested Effective Date of Policy: _____ / ___ / _____ (MONTH / DAY / YEAR)
6. Are you a member of a professional association? ☐ Yes ☐ No
   Name of association: _____
7. If you have a current policy, please list the expiration date:
   _____ / ___ / _____ (MONTH / DAY / YEAR)
8. Please list your current carrier: _____
   _____
9. Is your policy claims made?..... ☐ Yes ☐ No
10. Have any claims been made against a student, faculty member or the school for incidents in the providing of or failure to provide professional services in the past?..... ☐ Yes ☐ No
    (If "Yes", Please provide complete details on a separate sheet of paper and attach to application)
11. Have you ever had professional liability insurance declined,cancelled or non-renewed for any reason other than non-payment of premium?..... ☐ Yes ☐ No
    (not applicable for MO residents)
12. Is your school: ☐ Accredited ☐ Non-accredited
    If Non-accredited, please submit state approval.
13. How long has your school been in existence? _____
14. List additional location(s) addresses: _____
    _____
    _____
    _____

2. Choose Your Plan

PLAN A $1MM/$5MM	☐ STUDENTS **$13 Each Student**	FACULTY **Included**	SCHOOL **Included**	NUMBER OF STUDENTS _____ X$13	MEMBERSHIP FEE* +$10	TOTAL ESTIMATED AMOUNT = _____
PLAN B $2MM/$5MM	☐ STUDENTS **$16 Each Student**	FACULTY **Included**	SCHOOL **Included**	NUMBER OF STUDENTS _____ X$16	MEMBERSHIP FEE* +$10	TOTAL ESTIMATED AMOUNT = _____

Your school may be eligible for a discount. Note: minimum premium for an annual period is $300.00

Discount information to be completed by HPSO.

We will review your application for appropriate discount opportunities.

Please see last page of application for compensation disclosure information.

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*All applicants must add Healthcare Providers Service Organization Purchasing Group Fee of $10.00 for School institutions. Please see last page of application for compensation disclosure information.

G-144929-A (1/03)

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3. Area of Practice

Name of School: _____

Please estimate the number of students from the Healthcare Specialties listed below to be enrolled durig the policy period. If there is more than one session, please indicate the total number of students for all sessions.

_____Art Therapist
_____Athletic Trainer
_____Audiologist
_____Bio-Med/Biotechnology
_____Blood Bank Tech
_____Cardiology Tech
_____Central Service Tech
_____Certified Medical Assistant
_____Certified Medical Aid
_____Child Development
_____Chiropractic Asst
_____Chiropractic Technician
_____Clinical Lab Tech
_____Coding/Medical Billing
_____Community Health Asst
_____Community Health Tech
_____Corrective Therapist

Counseling Professionals
_____- Alcohol/Drug
_____- Clinical Counselor/LPCC
_____- Marriage/Family
_____- Pastoral
_____- Personnel/Guidance/School
_____- Psychotherapist
_____- Wellness
_____- Clinical/Rehab/Mental Health

_____Dance Therapist
_____Dental Asst
_____Dental Hygienist
_____Dental Lab Tech
_____Diagnostic Medical Sonographer
_____Dialysis Tech
_____Dietitian
_____EEG Tech
_____EKG Tech
_____Electrologist
_____EMS-Paramedic
_____EMS-Basic/Intermediate
_____EMS-Volunteer
_____EMS-First Responder
_____Enterostomal Therapist
_____Exercise Physiologist
_____Exercise Science
_____Gerontology
_____Health Care/Service Admin
_____Health Educator
_____Health Science
_____Histologic Tech
_____Hospital Pharmacy Tech
_____Human Services
_____Interpreter for the Deaf
_____Kinesiologist/Kinesiotherapist
_____Laboratory Aide
_____Laboratory Tech
_____Mammography Technician
_____Massage Therapist
_____Medical Assistant
_____Medical Lab Tech
_____Medical Records Admin
_____Medical Records Tech
_____Medical Tech Asst
_____Medical Technologist
_____Medical Preparation Tech
_____Medication Aide tech
_____Mental Health Tech
_____Mental Retardation Worker
_____MRI Tech
_____Music Therapist
_____Nuclear Medical Tech

Nurse
_____- RN First Assist
_____- RN
_____- Home Health Aide
_____- LPN/LVN
_____- Nurse's Aide
_____- Nursing Asst
_____- Nurse Refresher

Nurse Practitioner
- Geriatric/Adult or Family
_____ Planning/OBGYN
_____- Psychiatric
- Pediatric/Family Practice/Neonatal
_____ /OBGYN
_____Nutritionist
_____Occupational Therapist
_____Occupational Therapist Asst
_____Optometry Tech/Asst
_____Orthopedic Asst
_____Orthotic/Prosthetics
_____Patient Care Asst
_____Patient Care Technician
_____Pedorthist
_____Pharmacist
_____Phlebotomist
_____Physical Therapist
_____Physical Therapist Asst
_____Physical Therapy Aide
_____Physician Assistant
_____Podiatric Asst
_____Polysomnographer
_____Psychological Therapist
_____Radiation Therapist
_____Radiologic Tech
_____Recreation Therapist
_____Rehabilitation Asst
_____Rehabilitation Therapist
_____Renal Dialysis Tech
_____Respiratory Therapist
_____Social Worker
_____Sonographer
_____Speech Hearing Therapist
_____Speech Language Pathologist
_____Sports Medicine Instructor
_____Sports Medicine Therapist
_____Surgical Assistant
_____Surgical First Assist
_____Surgical Technologist
_____Ultrasound Technician
_____Veterinary Technician
_____X-Ray Technician
_____X-Ray Machine Operator

OTHER:
Please use the following space if you need coverage for any students whose specialty is not listed above.

NOTE: You must include the number of students for each specialty listed.

Continue to next page of Application

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4. Agreement

Name of School: _____

have answered these questions to the best of my knowledge. I certify that I hold the highest credentials or standards appropriate for the healthcare profession for which I have applied as mandated by my state guidelines. I have not withheld information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete this insurance**.** It is agreed that this Application shall be on file with the Company and that it shall be deemed to be attached to and made part of the policy, if issued, as if physically attached to the policy. I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my insurance coverage. This application will be the basis of the contract if a Certificate of Insurance is issued. Once approved, I understand that there is no coverage in force until the premium is paid in full. I have read and consent to the compensation terms below.

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties (For District of Columbia residents only: 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.) (For Florida residents only: 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.) (For Louisiana residents only: 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.) (For Maine residents only: 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.) (For Maryland residents only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) (For New York residents only: 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.) (For Oklahoma residents only: 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.) (For Pennsylvania residents only: 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.) (For Tennessee and Washington residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.)

5. Signature

Please Print Name _____

Applicant Signature **X** _____ Date: ___ / ___ / ___ (MONTH / DAY / YEAR)

This application must be fully completed, signed and dated in ink. We will issue your certificate of insurance upon approval.

Agent/Broker Information:

Agency Name: _____ **Contact Name:** _____

Address _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

COMPENSATION and OTHER DISCLOSURE INFORMATION

Healthcare Providers Service Organization (HPSO), a registered trade name of Affinity Insurance Services, Inc., exclusively offers the HPSO Program as an agent of CNA and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

Affinity Insurance Services Inc. is an insurance producer licensed in your state. Insurance producers are authorized by their license to confer with insurance purchasers about the benefits, terms and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction involves one or more of these activities. Compensation will be paid to the producer, based on the insurance contract the producer sells. Depending on the insurer(s) and insurance contract(s) the purchaser selects, compensation will be paid by the insurer(s) selling the insurance contract or by another third party. Such compensation may vary depending on a number of factors, including the insurance contract(s) and the insurer(s) the purchaser selects. In addition, Affinity may charge a fee for administrative services**.** Your signature on your application, quote form, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Aon. The insurance purchaser may obtain information about compensation expected to be received by the producer based in whole or in part on the sale of insurance to the purchaser, and compensation expected to be received based in whole or in part on any alternative quotes presented to the purchaser by the producer, by calling 1-800-982-9491.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. When they exist, these investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon web site at **http://www.aon.com/market_relationships** for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interest.

Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit **http://www.aon.com/market_relationships** for more detail on these agreements.