



YES! I want Individual Professional Liability Insurance Coverage with limits of up to \$3,000,000 aggregate, up to \$1,000,000 each claim. (17)

PLEASE PRINT CLEARLY AND COMPLETE THE FOLLOWING:

A3SA2HFX

Name: _____ Day Telephone #: _____
Home Address: _____ Night Telephone #: _____
City: _____ Fax #: _____
State: _____ Zip code: _____ E-mail: _____

Please answer ALL questions and SIGN and DATE this application. Incomplete applications cannot be processed.

1. Please find your profession on the profession list (page 3) and write it in below. Next, enter your state of residency. Part time is 24 hours or less per week.

Profession: _____

- Employed/Full Time
- Employed/Part Time
- Self Employed/Full Time
- Self Employed/Part Time

Recent Graduate If you have graduated within the previous 12 months and you are applying for full-time coverage, you are eligible for a 50% discount off your premium.

1b. If you are employed, please provide the following:

Name of employer: _____ City: _____ State: _____

Please note: *Employed* is defined as providing services on behalf of an entity you do not own, and receiving a W-2 form from your employer. *Self-employed* is defined as providing services as an independent contractor and paying self-employment taxes using a 1099 form. If you are incorporated with or without employees, please call 1-888-288-3534.

2. My primary area of work is (choose one):

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Ambulatory Care Facility (1) | <input type="checkbox"/> Home Health (05) | <input type="checkbox"/> Nursing School (09) | <input type="checkbox"/> Surgicenter (13) | <input type="checkbox"/> Research Center (18) |
| <input type="checkbox"/> Comm. Health Agency (02) | <input type="checkbox"/> Hospice (06) | <input type="checkbox"/> Prison (10) | <input type="checkbox"/> My own premises (14) | <input type="checkbox"/> Industry (19) |
| <input type="checkbox"/> Doctor's Office/Clinic (03) | <input type="checkbox"/> Hospital (07) | <input type="checkbox"/> School (11) | <input type="checkbox"/> Outpatient Facility (16) | <input type="checkbox"/> Fire/Rescue Station (20) |
| <input type="checkbox"/> HMO/PPO (04) | <input type="checkbox"/> Nursing Home (08) | <input type="checkbox"/> Staffing Agency (12) | <input type="checkbox"/> Health & Wellness Facility (17) | <input type="checkbox"/> Rehab Facility (21) |
| <input type="checkbox"/> Other (15) _____ | | | | |

3. Social Security #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____
MONTH DAY YEAR

4. Requested Effective Date: _____ / _____ / _____ (Must be within 60 days from the date we receive your application. If date indicated is prior to receipt date or if not filled out, the effective date will be the receipt date.)
MONTH DAY YEAR

5. Are you a member of a professional association?..... Yes No Name of Association: _____

6. Have you ever had professional liability insurance declined, canceled or non-renewed for any reason other than for non-payment of premium? (Not applicable for MO residents)..... Yes No

7. Has any claim or lawsuit for malpractice ever been brought against you or are you aware of any incidents that may result in a claim or lawsuit?..... Yes No

8. Within the last 5 years, have you 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
(If you have answered "yes" to questions 6, 7 or 8, please provide complete details on a separate sheet of paper and attach to application.)

Insurance Agent: Michael J. Loughran Iowa License# IA241616; Florida License# A158896

Payment Options:

Enclosed is my check. (Payable to: HPSO) Charge my credit card: AMEX Visa MasterCard Discover

Card #: _____ Expiration Date: ____ / ____

*All applicants must add a Healthcare Providers Service Organization Purchasing Group Membership Fee (\$2.00) Residents of NJ and WV must first add a state mandated surcharge to your base premium (FL: 0.85, NJ: 0.70%, KY: 1.85, WV: 0.55%). To calculate your total amount due, please add your base premium, state surcharge (if applicable) and membership fee. If you are paying by credit card, your card will be charged as detailed above.

Agent/Broker Information:

Agency Name: _____ Contact Name: _____

Address _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Simple Enrollment



1. Complete all pages.
2. Print your name, sign and date in ink.

3. Send **all pages** of the application. We cannot process if **all pages** are not received.




Continue to next page.

I 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 understand that a state mandated surcharge will be added to my annual premium if I am a resident of FL: (0.85%), KY(1.8%), NJ (0.70%) or WV (0.55%). 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.)

 **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.

This program is underwritten by American Casualty Company of Reading, Pennsylvania, a CNA company, and is offered through the Healthcare Providers Service Organization Purchasing Group. Coverages, rates and limits may differ or may not be available in all states. All products and services are subject to change without notice. CNA is a registered trademark of CNA Financial Corporation. Copyright © 2014 CNA. All rights reserved



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The Consulting Services Liability Endorsement

Are you consulting, teaching or training in addition to providing direct patient care?

This professional liability policy provides coverage if there is an act, error or omission in providing professional services which results in injury. However, economic or financial loss, through your participation in activities such as public speaking or providing expert testimony, typically would not be covered by your professional liability policy. It's a risk you don't have to take. The Consulting Services Liability Endorsement provides coverage for when you use your professional skills and knowledge in settings that do not involve direct treatment of clients. You can add this valuable protection to your new policy for only \$25 a year.

For more information, visit www.hpso.com/consult.

COMPENSATION and OTHER DISCLOSURE INFORMATION

Healthcare Providers Service Organization, 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 advise insurance purchasers about the terms and conditions of particular insurance contracts and to assist in the sale and binding of such policies. Compensation will be paid to the producer by the insurer and/or a third party based on the insurance contract the producer sells. 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 this application, or your authorization for payment, is your acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Affinity. You may obtain additional information about compensation received or expected to be received by Affinity regarding the CNA quote on any alternative quotes presented to the purchaser by Affinity, by contacting member services at 1-800-982-9491. In addition, premiums paid to Affinity for remittance to insurers, refunds and claim payments paid to Affinity by insurance companies are deposited into fiduciary accounts in accordance with applicable insurance laws. 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. Our liability to you, in total, for the duration of our business relationship for any and all damages, costs, and expenses (including but not limited to attorneys' fees), whether based on contract, tort (including negligence), or otherwise, in connection with or related to our services (including a failure to provide a service) that we provide in total shall be limited to the lesser of \$6,000,000 or the singular annual limit of the policy of insurance procured by us on your behalf from which your damages first arise. This liability limitation applies to you, our client, against Affinity, and its parent(s), affiliates, subsidiaries and their respective directors, officers, employees and agents (each an "Affinity Group Member"). Nothing in this liability limitation section implies that any Affinity Group Member owes or accepts any duty or responsibility to you. If you assert any claims or make any demands against us or any Affinity Group Member for a total amount in excess of this liability limitation, then you agree to indemnify Affinity for any and all liabilities, costs, damages and expenses, including attorneys' fees, incurred by Affinity or any Affinity Group Member that exceeds this liability limitation. Aon Corporation, our parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. 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 website at http://www.aon.com/market_relationships for a current listing of such relationships.

A full copy of the Affinity compensation and other disclosure information can be found at www.hpso.com/disclosure.

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.

Please select your profession from below, and write in on page 1.

- | | | |
|--|---|--|
| <input type="checkbox"/> Art Therapist | <input type="checkbox"/> EEG Tech | <input type="checkbox"/> Orthotics/Prosthetics |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> EKG Tech | <input type="checkbox"/> Patient Care Asst |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Electrologist | <input type="checkbox"/> Patient Care Technician |
| <input type="checkbox"/> Bio-med/Biotechnology | <input type="checkbox"/> EMS-Paramedic | <input type="checkbox"/> Pedorthist |
| <input type="checkbox"/> Bio-med Tech | <input type="checkbox"/> EMS-Volunteer | <input type="checkbox"/> Perfusionist |
| <input type="checkbox"/> Blood Bank Tech | <input type="checkbox"/> EMS-First Responder | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Central Services Tech | <input type="checkbox"/> Enternostomal Therapist | <input type="checkbox"/> Pharmacist Asst/Tech |
| <input type="checkbox"/> Certified Medical Asst | <input type="checkbox"/> Exercise Physiologist | <input type="checkbox"/> Phlebotomist |
| <input type="checkbox"/> Certified Medical Aid | <input type="checkbox"/> Gerontology | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Child Development | <input type="checkbox"/> Health Care Services/Admin | <input type="checkbox"/> Physical Therapist Asst |
| <input type="checkbox"/> Chiropractic Asst | <input type="checkbox"/> Health Educator | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Chiropractic Technician | <input type="checkbox"/> Histologic Tech | <input type="checkbox"/> Podiatric Asst |
| <input type="checkbox"/> Circulation Tech | <input type="checkbox"/> Home Health Aide | <input type="checkbox"/> Polysomnographer |
| <input type="checkbox"/> Clinical Lab Tech | <input type="checkbox"/> Hospital Pharmacy Tech | <input type="checkbox"/> Psychological Therapist |
| <input type="checkbox"/> Coding/Medical Billing | <input type="checkbox"/> Kinesiologist/Kinesiotherapist | <input type="checkbox"/> Radiation Therapist |
| <input type="checkbox"/> Community Health Asst | <input type="checkbox"/> Laboratory Aide | <input type="checkbox"/> Radiologic Tech |
| <input type="checkbox"/> Community Health Tech | <input type="checkbox"/> Laboratory Tech | <input type="checkbox"/> Recreation Therapist |
| <input type="checkbox"/> Corrective Therapist | <input type="checkbox"/> Mammography Tech | <input type="checkbox"/> Rehabilitation Assistant |
| Counselor | <input type="checkbox"/> Medical Assistant | <input type="checkbox"/> Rehabilitation Therapist |
| <input type="checkbox"/> Alcohol/Drug | <input type="checkbox"/> Medical Lab Tech | <input type="checkbox"/> Renal Dialysis Tech |
| <input type="checkbox"/> Marriage/Family | <input type="checkbox"/> Medical Tech Assistant | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Pastoral/Guidance | <input type="checkbox"/> Medical Records Admin | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> School | <input type="checkbox"/> Medical Technologist | <input type="checkbox"/> Sonographer |
| <input type="checkbox"/> Wellness | <input type="checkbox"/> Medical Preparation Tech | <input type="checkbox"/> Speech Hearing Therapist |
| <input type="checkbox"/> Clinical/Rehab/Mental Health | <input type="checkbox"/> Mental Health Tech | <input type="checkbox"/> Speech Language Pathologist |
| <input type="checkbox"/> Other (write below & on page 1) | <input type="checkbox"/> Mental Retardation Work | <input type="checkbox"/> Sports Medicine Instructor |
| _____ | <input type="checkbox"/> MRI Tech | <input type="checkbox"/> Sports Medicine Therapist |
| _____ | <input type="checkbox"/> Music Therapist | <input type="checkbox"/> Surgical Assistant |
| <input type="checkbox"/> Dance Therapist | <input type="checkbox"/> Nuclear Medical Tech | <input type="checkbox"/> Surgical First Asst |
| <input type="checkbox"/> Dental Asst | <input type="checkbox"/> Nurse's Aide | <input type="checkbox"/> Surgical Technologist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Nursing Assistant | <input type="checkbox"/> Ultrasound Technician |
| <input type="checkbox"/> Dental Lab Tech | <input type="checkbox"/> Nutritionist | <input type="checkbox"/> Vascular Technician |
| <input type="checkbox"/> Diagnostic Medical | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> X-Ray Technician |
| <input type="checkbox"/> Dialysis Tech | <input type="checkbox"/> Occupational Therapist Asst | <input type="checkbox"/> Other (write below & on page 1) |
| <input type="checkbox"/> Dietician | <input type="checkbox"/> Optometry Tech/Asst | _____ |
| | <input type="checkbox"/> Orthopedic Asst | _____ |