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Application

MEDICAL FACILITIES AND PROVIDERS NON-MEDICAL PROFESSIONAL LIABILITY SUPPLEMENTAL APPLICATION

This Supplemental Application is part of the Medical Facilities and Providers Liability Application.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the Medical Facilities and Providers Liability Application):	

B. FINANCIAL AND EXPOSURE DETAILS

2. Describe the non-medical professional services for which coverage is desired and indicate the approximate percentage of current revenue derived from each:

Professional Services	Percentage of Revenue
	%
	%
	%

3. When did the Applicant begin providing these professional services? Month/Year:_____

4. Indicate the total annual revenue derived from the professional services described in Section B.2. List revenue for the past two (2) years and projected revenue for the current year:

	Year	Revenue
a.	(Current)	$ (Projected)
b.		$
c.		$

5. List the Applicant's three (3) largest clients and identify the professional services provided and revenues derived from each:

Client	Professional Services	Revenue
		$
		$
		$

C. OPERATIONS AND ADMINISTRATION

6. Only with respect to the professional services described in Section B.2., does the Applicant:

a. Have written standard operating procedures? ☐ Yes ☐ No

b. Have a formal training program? ☐ Yes ☐ No

c. Use a written contract with clients? ☐ Yes ☐ No

d. Subcontract work to others? ☐ Yes ☐ No

D. CURRENT AND REQUESTED COVERAGE

7. Does the Applicant currently have professional liability in force for these professional services? ☐ Yes ☐ No

E. REQUIRED INFORMATION

8. Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.
   - Sample copies of client service contracts;
   - Any promotional literature used by the Applicant

F. SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplemental Application and any attachments of information submitted with this Supplemental Application are true and complete. The undersigned understands that information submitted herein becomes part of the Applicant's Medical Facilities and Providers Liability Application and is subject to the representations and conditions set forth therein.

NOTICE: 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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER, PRESIDENT, CHAIRMAN OR OTHER OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.