

ALLIED HEALTHCARE CONSULTANTS PROFESSIONAL LIABILITY APPLICATION

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Applicant Name: _____
2. Mailing Address: _____

3. Location Address(es): _____

4. County (parish) of Each Location: _____

5. Telephone Number: Office: _____ Fax: _____
6. Person to Contact for Survey: Name: _____ Title: _____
7. Date Established: _____
8. The applicant is: Corporation
 Sole Practitioner Other; Describe: _____
 Sole Proprietorship _____
 Partnership _____
9. Gross Annual Receipts: Estimated Next 12 Months: \$ _____
Last 12 Months: \$ _____
10. Entity is: For Profit Non-Profit
Describe source of funds: _____

PART II. EXPOSURES

1. List the applicant's consulting activities and indicate the percentage of gross receipts derived from each activity:
 - a) _____%
 - b) _____%
 - c) _____%
 - d) _____%

2. Does the applicant sell, promote, or perform any service other than listed in Item 1? [] Yes [] No
3. Does the applicant consult on means or methods of financing or obtaining funds including, but not limited to, loans, grants, mergers, acquisitions, capitalizations, divestitures, or liquidations? [] Yes [] No
4. Is the applicant involved in the management, purchase, sale, or maintenance of any real or personal property or in any activity related in any way to investments or investing including, but not limited to, securities, time deposits, annuities, futures contracts, partnerships, syndications, or tax shelters? [] Yes [] No
5. Does the applicant consult on, supervise, or manage any escrow accounts, trust funds, or insurance plans? [] Yes [] No
6. Does the applicant sell, distribute, design, manufacture, recommend, or test any product or process for creating a product? [] Yes [] No
7. Does the applicant perform any design or consulting services in relation to any lotteries, sweepstakes, or any game of chance? [] Yes [] No
8. Has the applicant agreed to manage the operations of any business on behalf of any client, or does the applicant assist in negotiating or have any authority to enter into contractual relationships on any client's behalf? [] Yes [] No
9. Does the applicant provide psychological counseling services or an alcohol, drug, or other substance abuse counseling, therapy, or rehabilitation of any kind? [] Yes [] No

If the answers to any one of the above questions are "yes," then please provide full details.

10. List memberships in professional organizations: _____

PART III. RISK MANAGEMENT

1. Total number of staff: _____
2. Total payroll last year: _____
Total payroll next year: _____
3. Do you desire coverage for independent contractor(s) as additional insured(s) on your policy while working on your behalf? [] Yes [] No
4. Do you require contracted staff to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [] Yes [] No
If yes, indicate minimum limits required: _____
4. Do you conduct pre-employment screening and investigation? [] Yes [] No

5. Do you prepare job descriptions and instructional manuals for your staff? [] Yes [] No
6. Has the applicant or any employees:
- a. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [] Yes [] No
 - b. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [] Yes [] No
 - c. ever been treated for alcoholism or drug addiction? [] Yes [] No
 - d. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? [] Yes [] No

If Yes to any of the above, please explain.

PART IV. HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date? _____

2. List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date? _____

3. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [] Yes [] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

4. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [] Yes [] No

If yes, describe the event and indicate the reason for anticipation of a claim: _____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and MarketScout, any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

Applicant Signature

Title

Date