Bill Beatty **Insurance Agency, Inc.**

MEDICAL ASSISTANTS
Professional Liability Insurance Application (05.06)

PRINT OR TYPE * PLEASE COMPLETE FORM IN ITS ENTIRETY TO AVOID DELAY

_____ _____/_____/_____

FULL NAME OF APPLICANT **DATE OF BIRTH / S.S.N. OR FEDERAL TAX I.D./ PROF. LICENSE NUMBER**

_____INC. or ____ DBA

_____**and/or**_____

BUSINESS NAME (IF SELF EMPLOYED) **EMPLOYER NAME IF EMPLOYED**

_____ _____

ADDRESS **TELEPHONE NUMBER / FAX NUMBER**

_____ _____

CITY **STATE** **ZIP** **BUSINESS TELEPHONE NUMBER/ REQUESTED EFFECTIVE DATE**

1) Has your license ever been suspended, revoked, cancelled, non-renewed, put on probation or voluntarily surrendered? ___Yes ___No
2) Have you ever had a claim made, suit brought against you, or are you aware of any professional incident that might reasonably lead to a claim or suit? ___Yes ___No
3) Has your professional liability insurance ever been suspended, revoked, cancelled or non-renewed? ___Yes ___No

If the answer to any of the above questions is yes, please explain on a separate sheet.

	LIMITS & RATES		
	$500,000/$1,000,000 per occurrence/aggregate	**$1,000,000/$3,000,000 per occurrence/aggregate**	**$2,000,000/$4,000,000 per occurrence/aggregate**
A) EMPLOYED MEDICAL ASSISTANT	$86	$104	$122

All applicants sign and date below: I understand that I am not covered by this insurance if I am any of the following**:** Physician, Surgeon, Dentist, Nurse Midwife, Chiropractor, Podiatrist, Acupuncturist, Nurse Anesthetist, Osteopath, Psychiatrist, Cytotechnologist, Perfusionist, or Electroneurodiagnostic Technologist. I understand that these professions are excluded from this coverage. I understand that this insurance will not apply to any partner, principal or owner of a residential/overnight facility. The insurance described herein is subject to terms, conditions and exclusions of the insurance certificate.

In order to enhance the stability of this professional liability insurance program, coverage has been organized through a purchasing group, pursuant to legislation, known as the Federal Liability Retention Act of 1986, enacted by Congress. Coverage is provided to the purchasing group by Chicago Insurance Company, a member of Interstate National Corporation, one of the Fireman's Fund Insurance Companies. Once the completed application has been approved and the premium has been received, you will automatically become a member of the Allied Health Purchasing Group Association, located and domiciled in Illinois and obtain the insurance coverage afforded through the group policy on an annual term.

This application is subject to underwriter's approval. Your completion of this application and premium payment does not bind coverage or obligate the insurance company to issue you coverage. Coverage will become effective following the receipt of your acceptable application and premium payment. Your application cannot be processed unless it is completed in its entirety. The application is subject to the company's underwriting rules.

I declare the information contained in the application is true and that no material facts have been suppressed or misstated. I understand that incorrect information could void the protection. Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, and may void coverage.

Applicant Signature_____ Amount Enclosed $_____ Date_____

COVERAGE IS SUBJECT TO COMPANY APPROVAL

Please allow 2 to 3 weeks for processing of your insurance.

Make check payable to: Bill Beatty Insurance Agency, Inc. - 1202 Richardson Dr, Suite 100 - Richardson, Texas 75080 - 972/644-4281 or 800/451-8358 Fax 972/437-3759

This brochure contains only a summary of the policy provisions. If any conflict exists with the actual policy, the terms of the policy control.