

Bill Beatty

Insurance Agency, Inc.

PHYSICAL THERAPY BUSINESS
Professional Liability Insurance Application (05/07)

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

NAME OF APPLICANT (Name of each owner, partner or corporate officer active in physical therapy)

DATE OF BIRTH

BUSINESS or CORPORATE NAME (DBA)

S.S.N. / PROF. LICENSE NUMBER

ADDRESS

HOME TELEPHONE NUMBER

CITY STATE ZIP

BUSINESS TELEPHONE NUMBER/FAX NUMBER

Please indicate type of business: ___ Corporation ___ Partnership ___ Sole Proprietor ___ Other

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

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

Table with 4 columns: Category, \$500,000/\$1,000,000 per occurrence/aggregate, LIMITS & RATES \$1,000,000/\$3,000,000 per occurrence/aggregate, \$2,000,000/\$4,000,000 per occurrence/aggregate

A) SELF-EMPLOYED APPLICANTS

Number of partners, owners and officers:

Self-Employed (full and/or part-time) @ \$478 = \$ @ \$576 = \$ @ \$674 = \$

All Employees of Physical Therapy Groups

Employees: Physical Therapist @ \$311 = \$ @ \$375 = \$ @ \$439 = \$

Physical Therapist Assistant @ \$311 = \$ @ \$375 = \$ @ \$439 = \$

Others (please specify occupation below) @ \$311 = \$ @ \$375 = \$ @ \$439 = \$

Occupations: _____

Number of Independent Contractors @ \$42 = \$ @ \$50 = \$ @ \$59 = \$

Insures the business for the acts of Independent Contractors

NOTE: Premium must be paid for each employee and each independent contractor who provides a health care service.

REQUIRED: Please describe your business operation and attach any brochures or handouts used in the business.

B) ADDITIONAL INSURED

Premium is for each owner or facility under contract for whom you must provide Coverage. (Please provide name and address of each on a separate sheet.)

Professional Liability Only @ \$104 = \$ @ \$125 = \$ @ \$146 = \$

Professional & General Liability @ \$125 = \$ @ \$150 = \$ @ \$176 = \$

C) GENERAL LIABILITY

Main (original) location @ \$100 = \$ @ \$120 = \$ @ \$140 = \$

Each additional location @ \$42 = \$ @ \$50 = \$ @ \$59 = \$

For all locations - provide addresses on a separate sheet, excluding patient residences.

SUBTOTAL OF SECTIONS A), B), AND C) \$ \$ \$

MULTIPLY BY 1.15 IF A GROUP \$ \$ \$

MULTIPLY BY 1.20 IF 40% OR MORE OF TOTAL SERVICES TO WORKERS COMPENSATION PATIENTS \$ \$ \$

ROUND TO THE NEAREST DOLLAR TO CALCULATE TOTAL

Exposure Questions:

- 1) Are all professionals listed on the application certified and/or licensed for the duties they are performing? ___Yes ___No
- 2) Have you verified that all independent contractors have coverage at least equal to the amount for which you are applying? ___Yes ___No
- 3) Do you own or operate a staffing agency? ___Yes ___No
- 4) Do you own or operate a Health Club/Fitness/Exercise and/or Wellness Center or Sports Endurance or Enhancement Facility? ___Yes ___No
- 5) Do you own or operate a facility providing overnight care? ___Yes ___No
- 6) Do you own or operate a business other than Physical Therapy and/or medical rehabilitation? ___Yes ___No
- 7) Do you administer anesthetics or radiation therapy? ___Yes ___No
- 8) Do you offer weight control and/or diet programs? ___Yes ___No
- 9) Do you provide treatment or assessment in a nursing home and/or assisted living facility? ___Yes ___No
If yes, what percentage of your total treatment is provided in these facilities? _____%
- 10) Do you provide 40% or more of total services to Workers Compensation patients? ___Yes ___No

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, Sonographer, 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 delivery of your certificate of 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.

Bill Beatty

Insurance Agency, Inc.

**1202 Richardson Dr., Suite 100
Richardson, Texas 75080
(972)644-4281 * (800)451-8358 * (972)437-3759 Fax**

**Underwritten by:
Chicago Insurance Company
Chicago, Illinois**

**One of the Interstate Insurance Companies, a subsidiary of the Fireman's Fund Insurance Companies,
rated "Excellent" by the Independent A. M. Best Company.**

Thank you for doing business with a Texas agent providing medical professional liability insurance since 1962.