Bill Beatty **INSURANCE AGENCY, INC.**

SPEECH AND HEARING THERAPY

Professional Liability Insurance Application (02.10)

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

FULL NAME OF APPLICANT _____ **DATE OF BIRTH** ____/____/____ **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** _____

Are you a….

____ Speech & Hearing Pathologist/Therapist ____ Audiologist

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 or 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/$500,000 per occurrence/aggregate	**$1,000,000/$3,000,000 per occurrence/aggregate**	**$2,000,000/$4,000,000 per occurrence/aggregate**
A) EMPLOYED ONLY	☐ **$50**	☐ **$79**	☐ **$92**
B) SELF-EMPLOYED Professional Liability (self-employed rates cover both self employed and employed duties)			
Number of partners or owners:	____@ $91 = $_____	____@ $ 143 = $_____	____@ $167 = $_____
Number of employees who provide a health care service:			
Employees: Therapists	____@ $ 32 = $_____	____@ $ 39 = $_____	____@ $ 46 = $_____
Employees: Other Occupations (please call for rates)	____@ $___ = $_____	____@ _____ = $_____	____@ $____ = $_____
C) ADDITIONAL INSURED Premium is for each facility under contract for whom you must provide coverage. Please provide names and addresses on a separate sheet.	____ @ $129 = $_____	____@ $156 = $_____	____@ $183 = $_____
D) GENERAL LIABILITY			
Main (original) location	____@ $83 = $_____	_____@ $ 95 = $_____	_____@ $111 = $_____
Each additional location	____@ $33 = $_____	_____@ $38 = $_____	_____@ $ 44 = $_____
TOTALS	**$ _____**	**$_____**	**$_____**

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

_____

_____

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 Drive, 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.