



PROFESSIONAL and GENERAL LIABILITY APPLICATION MEDICAL ARTS SCHOOL

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple names and locations, please attach list)
4. Telephone Number: _____ Website Address: _____ Date Established: _____

Section 2: Coverage Requested

5. Effective Date: _____
6. Liability Limits: \$ _____ / \$ _____
7. Deductible: \$ _____

Section 3: Financial Information and Operations

8. Gross Receipts (Past 12 Months): \$ _____
9. Estimated Gross Receipts (Next 12 Months): \$ _____
10. Specify the license(s) under which the applicant's services are authorized to operate: _____

11. Does the applicant have any ancillary operations not stated above? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No
12. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No
13. Please complete the table below by identifying each type of class offered, the total number of students instructed annually, and the length or duration of each class:

Start-Up Applicants: If operations have not yet commenced, please provide estimated percentage exposures for the next twelve (12) months for each category listed below.



Type of Class	Number of Students Taught Annually	Class Length / Duration

14. Are all services provided at the applicant's listed location address(es) referenced on Q3? ☐ Yes ☐ No
If No, please describe any off-site services and provide the approximate percentage performed at each location type:

15. Does the applicant offer any externship programs? ☐ Yes ☐ No
If Yes, please complete the table below for each externship exposure:

Externship Location	Duration of Externship	Services Provided by Students	Staff-to-Student Ratio

16. Does the applicant confirm that all facilities where externships or any hands-on training or experience are conducted maintain their own Professional and General Liability insurance with minimum limits of \$1M/\$3M, and secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No

Section 4: Staffing

17. Employee and Independent Contractor Details:

a) List the **NUMBER** and type of **EMPLOYEES**:

EMPLOYEES	FULL-TIME	PART-TIME	EMPLOYEES	FULL-TIME	PART-TIME
Chiropractor			Nurse Practitioner (NP)		
Clerical / Administrative			Paramedic / EMT		
CRNA / Surgical Technician			Physician / Dentist		
Home Health Aide / Homemaker			Physician Assistant (PA)		
LPN / LVN			Registered Nurse (RN)		
Massage Therapist			All Others (Describe):		

b) List the **NUMBER** and type of **INDEPENDENT CONTRACTORS**: ☐ If None

INDEPENDENT CONTRACTORS	FULL-TIME	PART-TIME	INDEPENDENT CONTRACTORS	FULL-TIME	PART-TIME
Chiropractor			Nurse Practitioner (NP)		
Clerical / Administrative			Paramedic / EMT		
CRNA / Surgical Technician			Physician / Dentist		
Home Health Aide / Homemaker			Physician Assistant (PA)		
LPN / LVN			Registered Nurse (RN)		
Massage Therapist			All Others (Describe):		

c) Are all individuals listed on Q17 subject to licensing requirements properly licensed?

☐ Yes ☐ No

If No, explain: _____

18. Are you seeking coverage under this proposed insurance for the independent contractors?

☐ Yes ☐ No

If No, is coverage at equal or greater limits maintained by each independent contractor?

☐ Yes ☐ No

19. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists, or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

☐ Yes ☐ No

If Yes, provide required limits: \$ _____ / \$ _____

Section 5: Employee Screening / Controls

20. Screening and Policies:

a) Do you conduct pre-employment screening and investigation?

☐ Yes ☐ No

b) Are employees required to actively participate in continuing education?

☐ Yes ☐ No

c) Do you prepare job descriptions and instructional manuals for your staff?

☐ Yes ☐ No

d) Do you have a written incident/occurrence reporting policy and procedures?

☐ Yes ☐ No

21. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:

☐ Applications/Resumes

☐ Criminal Background Checks

☐ Licensure Verification

☐ Drug Testing

☐ Education/Training/Competence

Section 6: Regulatory and Inspection

22. Disclosure of Disciplinary or Legal History:

Attach a detailed explanation for any **YES** answers below:

Has the applicant or have any of the employees:

a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?

☐ Yes ☐ No



- b) Ever been convicted of any 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, accepted only on special terms, or voluntarily surrendered? ☐ Yes ☐ No

Section 7: Insurance History

Currently valued loss runs for all prior coverage are required.

23. Professional Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

24. General Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

Section 8: Claims and Incidents

25. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details) ☐ Yes ☐ No



26. Has any claim been made against the insured or its employees that would be covered by this policy in the past 5 years? ☐ Yes ☐ No
If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported)
27. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees that would be covered under this policy? (If Yes, attach details) ☐ Yes ☐ No

Signature and Attestation

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)