

NATIONAL STRENGTH AND CONDITIONING ASSOCIATION

Chicago Insurance Company
S.C. LP
NSCA-L-IM-1203

Professional Liability Insurance Application

How to apply: Simply complete the application, enclose your premium check made payable to Marsh Affinity and mail to the address provided on the back of this application. All premiums are annual. Coverage is effective the date your application is approved and payment is received. Please allow three to four weeks for delivery of your policy. **Please print or type all information. If you need assistance completing this application, call us toll-free at 1-800-456-0737.**

1. APPLICANT

ALL APPLICANTS MUST COMPLETE

LAST NAME FIRST NAME MIDDLE INITIAL

BUSINESS/CORPORATE NAME/DBA (FILL IN ONLY IF YOU ARE THE OWNER OF THE BUSINESS) FEDERAL TAX ID #

NUMBER OF OWNERS, PARTNERS, AND CORPORATE OFFICERS WHO ARE ACTIVE IN THE BUSINESS, WITH THEIR PROFESSIONAL OCCUPATION.

ADDRESS DAYTIME PHONE FAX NUMBER

CITY STATE ZIP CODE

BIRTHDATE (FOR IDENTIFICATION) E-MAIL ADDRESS

2. CLASSIFICATIONS AND ANNUAL PREMIUMS

ANNUAL PREMIUMS AND LIMITS

\$2,000,000 per incident/occurrence	\$1,000,000 per incident/occurrence	
\$4,000,000 aggregate	\$3,000,000 aggregate	

Employed Individuals: \$193.00 \$165.00

Self-Employed Individuals and Business Applicants () x \$562 = \$ _____ () x \$480 = \$ _____

*NY & CA Res only: Self-Employed (-20 Hours/per week) () x \$335 = \$ _____ () x \$286 = \$ _____

Professional Liability for Employees (Premium is for each employee). This coverage must be purchased for all professional employees. () x \$439 = \$ _____ () x \$375 = \$ _____

*NY Res. only Part-Time Employees (-20 Hours/per week) () x \$253 = \$ _____ () x \$216 = \$ _____

Other _____ (please specify) () x \$439 = \$ _____ () x \$375 = \$ _____

3. OPTIONAL COVERAGES

General Liability

Coverage for 1st Location \$140.00 \$120.00

Each additional location () x \$59 = \$ _____ () x \$50 = \$ _____

(List name and addresses of each facility on a separate sheet)

Additional Insured – This coverage is optional and is available only if Self-employed coverage is purchased.

Premium is for each facility under contract

Professional Liability & General Liability () x \$176 = \$ _____ () x \$150 = \$ _____

Professional Liability Only () x \$146 = \$ _____ () x \$125 = \$ _____

General Liability Only () x \$30 = \$ _____ () x \$25 = \$ _____

(List name and address of each facility on a separate sheet)

***Florida Residents – add 2.5% FIGAS Surcharge

***New Jersey Residents – add 1.6% PLIGA Surcharge: \$ _____ \$ _____

TOTAL PREMIUM DUE \$ _____ \$ _____

ALL APPLICANTS MUST COMPLETE AND SIGN THE BACK OF THE APPLICATION

4. MUST ANSWER

1. Have any of the following ever been revoked, suspended, refused, denied renewal, placed on probation, cancelled, or voluntarily surrendered by you or any of your employees or is such an action pending against you or any of your employees? (If "Yes", explain on a separate sheet. Please include dates and allegations).

State License or Certification Yes No

Malpractice Insurance ** Yes No

****NOTE TO MISSOURI RESIDENTS: THIS QUESTION DOES NOT APPLY.**

2. Has any claim or suit ever been brought against you or any of your employees or are you or any of your employees aware of any incident that might reasonably lead to a claim or suit? (If "Yes", explain on a separate sheet. Please include dates, allegations and amounts). Yes No

I understand that I am not covered by this insurance if I am any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, cytotechnologist, electroneurodiagnostic technologist, perfusionist or psychiatrist. I understand that these professional occupations are excluded from coverage. I understand that this insurance will not apply to any partner, principal or owner of a residential/overnight facility. This insurance described herein is subject to the terms, conditions and exclusions of the insurance certificate. This insurance is excess when other insurance applies to a loss.

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 Risk Retention Act of 1986, enacted by Congress. Coverage is provided to the purchasing group by the 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 Health Care Professionals 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 the underwriter's approval. Your completion of this application and premium payment does not bind coverage or obligate the insurance company to issue you insurance 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 this application is true and that no material facts have been suppressed or misstated. I understand that incorrect information could void protection. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Notice to New York Applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

YOU MUST SIGN AND DATE THIS APPLICATION

SIGNATURE: _____

DATE: _____

NSCA Membership Number: _____

Enclosed is my check for \$ _____ Effective Date Desired* _____

*May not be earlier than the date the administrator receives and approves this application.

Make check payable to Marsh Affinity and return with this application to Hagan Benefits, Inc. at the address below.

I authorize Marsh Affinity to charge my Visa MasterCard

Credit Card Number: _____

Expiration Date: _____

Amount: _____ Print Name exactly as it appears on card: _____

Arranged and managed by:
Hagan Benefits, Inc.
PO Box 5090
Sioux Falls SD 57117-5090
1-800-456-0737
Fax: 605-334-0556

Underwritten by:
Chicago Insurance Company
a member of the Interstate National Corporation, one of
The Fireman's Fund Insurance Companies.

NOTE: This is only a summary of the Insurance certificate provisions. If any conflict exists with the actual insurance certificate, the terms of the insurance certificate control.