

Completing your HPSO Application

1. Be sure to complete your application in INK. Applications completed in pencil will be returned.
2. Fill out your name, address and phone number at the top of the application.
3. Your "Date of Birth" and "Social Security #" are not required is not fields but will help us locate your information faster in our database. It will also help us distinguish you from other customers.
4. Next, Complete question 1. Be sure to mark whether you are employed or self-employed full time, employed or self-employed part time or student (if you are a student please complete the name of your school and anticipated graduation date).
 - a. If you hold any other licenses or certifications you must list them anywhere on the application.
5. Question 1a and 2 may be skipped if you are a student or self-employed.
6. If you have recently graduated complete the Recent Grad Section. You must have graduated within the last 12 months to be eligible for this discount.
7. If you are "employed" in your profession, please complete question 1a and 2, which are required fields. If you do not complete "name of employer" section your application will be returned to you.
8. Complete question 4. If you leave this blank the effective date will be the date we receive your completed application.
9. The three questions regarding any canceled or non-renewed policy, claims, or disciplinary actions (questions 6-8) must also be answered. Again, if these are not answered your application will be returned.
10. Finally, sign and date your application. If your application is not signed or currently dated it will be returned to you.

Also included with your application you will find a Benefits Guide and an Authorization and Release form. The Benefits guide is for your reference only, to inform you of the additional benefits provided under your policy. The authorization and release form gives us your permission to send a copy of your certificate of insurance to the school or company that you choose.

When completing the Authorization and Release form be sure to provide a fax number, if you wish us to forward your certificate of insurance for you, and to sign and date the form.

If you have any questions regarding your application please do not hesitate to call our toll-free number at 1-800-982-9491.

(Note: If you are completing a license or certification specific application question numbers may vary from above.)



Professional Liability Insurance Occurrence Application

for employed individuals

159 East County Line Road, Hatboro, PA 19040-1218 • Toll-Free #: 1-800-982-9491 • Fax #: 1-800-739-8818

PLEASE PRINT CLEARLY AND COMPLETE THE FOLLOWING:

___ FS6AEC

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Date of Birth: _____ / _____ / _____
Day Telephone #: (____) _____
Night Telephone #: (____) _____
Fax: (____) _____ E-Mail: _____

YES! I want Professional Liability Insurance with limits of up to \$3,000,000 aggregate, up to \$1,000,000 each claim. (17)

1. I am: Full-Time Part-Time (24 hours or less per week) Does your total employment exceed 24 hours per week? Yes No
 Retired (If you are retired, you may qualify for a 50% discount off the full-time rate, with reduced coverages.)

2. Indicate your classification or certification: _____
(See back of application for a list of professions and rates. Please PRINT your classification above.)

- Student Name of School _____ Graduation Date ____/____/____
- Recent Graduate (If you have completed your professional training in the previous 12 months, you may qualify for a 50% discount off the full-time rate.)

2a. If you are employed, please provide the following:

Name of employer: _____ City: _____ State: _____

Please Note: *Employed* is defined as providing services on behalf of an entity you do not own, and receiving a W-2 form from your employer. *Self-employed* is defined as providing services as an independent contractor and paying self-employment taxes using a 1099 form.

3. My primary area of work is (choose one):

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Ambulatory Care Facility (01) | <input type="checkbox"/> Home Health (05) | <input type="checkbox"/> Nursing School (09) | <input type="checkbox"/> Surgicenter (13) | <input type="checkbox"/> Research Center (18) |
| <input type="checkbox"/> Comm. Health Agency (02) | <input type="checkbox"/> Hospice (06) | <input type="checkbox"/> Prison (10) | <input type="checkbox"/> My own premises (14) | <input type="checkbox"/> Industry (19) |
| <input type="checkbox"/> Doctor's Office/Clinic (03) | <input type="checkbox"/> Hospital (07) | <input type="checkbox"/> School (11) | <input type="checkbox"/> Outpatient Facility (16) | <input type="checkbox"/> Fire/Rescue Station (20) |
| <input type="checkbox"/> HMO/PPO (04) | <input type="checkbox"/> Nursing Home (08) | <input type="checkbox"/> Staffing Agency (12) | <input type="checkbox"/> Health & Wellness Facility (17) | <input type="checkbox"/> Rehab Facility (21) |
| <input type="checkbox"/> Other (15) | | | | |

4. Are you a member of a professional association? Yes No
Name of Association: _____

5. Social Security # _____

6. Requested Effective Date of Coverage: ____/____/____ (Must be within 60 days following the application date.)

7. Have you ever had professional liability insurance declined, canceled or non-renewed for any reason other than for non-payment of premium? (Not applicable for MO residents) Yes No

8. Has any claim or lawsuit for malpractice ever been brought against you or are you aware of any incidents that may result in a claim or lawsuit? Yes No

9. Within the last 5 years, have you been the subject of complaints, charges, or disciplinary action against you for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of your profession? Yes No
(If you have answered "yes" to questions 7, 8 or 9, please provide complete details on a separate sheet of paper and attach to application.)

10. Do you currently carry: a) Homeowner's policy, b) Condominium owner's policy, c) Tenant homeowner's policy, d) None of the above?

11. I am: self-employed an employee (If you are incorporated or self-employed with employees, please call 1-888-288-3534.)

Insurance Agent: Michael J. Loughran Florida License #A158896

Payment Options: Send No Money Now — bill me later for my annual premium.
OR -- Need coverage right away? Apply now at www.hpso.com.

I have answered these questions to the best of my knowledge. I certify that I hold the highest credentials or standards appropriate for the healthcare profession for which I have applied as mandated by my state statutory guidelines. I have not withheld any information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I understand that a state mandated surcharge will be added to my annual premium if I am a resident of NJ (1.75%) or WV (0.55%).

FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. (For New York residents only: 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.) (For Pennsylvania residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

SIGNATURE: X _____ DATE: ____/____/____

THIS APPLICATION MUST BE FULLY COMPLETED, SIGNED AND DATED IN INK. WE WILL ISSUE YOUR CERTIFICATE OF INSURANCE UPON APPROVAL.

This program is underwritten by American Casualty Company of Reading, PA, a CNA company and is offered through the Healthcare Providers Service Organization Risk Purchasing Group. Coverages, rates and limits may differ in some states. CNA is a service mark and trade name registered with the U.S. Patent and Trademark Office.

Healthcare Providers Service Organization is a division and Nurses Service Organization is a registered trade name of Affinity Insurance Services, Inc.; in NY and NH, AIS Affinity Insurance Agency; in MN and OK, AIS Affinity Insurance Agency, Inc.; and in CA, AIS Affinity Insurance Agency, Inc. dba Aon Direct Insurance Administrators License #0795465.



G-135674-B (5/04)
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QUESTIONS? Call Toll-Free 1-800-982-9491
Fax 1-800-739-8818

www.hpso.com



M4/M5 A-2460-106

Rates are for employed individuals. (Please call 1-800-982-9491 if self-employed)
(\$1 million/\$3 million limits of liability)

CLASSIFICATION	FULL TIME	PART TIME	STUDENT	CLASSIFICATION	FULL TIME	PART TIME	STUDENT
• Art Therapist	\$89		\$29	• Medical Records Administrator	\$89		\$29
• Athletic Trainer	\$200	\$100	\$29	• Medical Records Tech.	\$89		\$29
• Audiologist	\$79		\$29	• Mental Retardation Worker	\$89		\$29
• Bio-Med Tech.	\$89		\$29	• Music Therapist ⁴	\$89		\$29
• Blood Bank Tech.	\$89		\$29	• Nuclear Medical Tech.	\$89		\$29
• Cardiology Tech.	\$89		\$29	• Nurse			
• Certified Lab Tech.	\$89		\$29	➢ Home Health Aide	\$89		\$29
• Certified Occupational Therapist Assistant	\$76		\$29	➢ Geriatric Nursing Assistant/ Nurses Aide/Nursing Assistant	\$49		\$29
• Chiropractic Assistant	\$89		\$29	➢ RN	1-800-247-1500		
• Circulation Tech.	\$150	\$100	\$29	➢ LPN/LVN			
• Clinical Lab Tech.	\$89		\$29	• Nurse Practitioner			
• Community Health Assistant	\$89		\$29	➢ Adult/Geriatric/ Family Planning-GYN only			
• Community Health Tech.	\$89		\$29	➢ Psychiatric	Please Call 1-866-216-8080 for the appropriate application		
• Corrective Therapist	\$175	\$100	\$29	➢ Family Practice/Pediatric/ Neonatal/Acute Critical Care			
• Counselors				➢ OB/GYN/ Perinatal/ Acute Care-OB/GYN			
➢ Alcohol/Drug/Clinical/ Counselor Educator/Forensic/ Genetic ¹ /Licensed Professional/ Life Coach ¹ /Marriage/Family/ Mental Health/Pastoral/ Rehabilitation/School/Vocational	\$120	\$100	\$29	• Nutritionist			
➢ Bodywork Counselor ¹	\$157	\$100	\$29	• Occupational Therapist	\$76		\$29
➢ Psychological Counselor	\$432	\$216	\$29	• Occupational Therapist Assistant	\$76		\$29
➢ Psychologist/Psychotherapist	\$432	\$216	\$29	• Optometric Tech/Assistant	\$89		\$29
➢ Social Worker	\$120	\$100	\$29	• Orthopedic Assistant	\$175	\$100	\$29
• Dance Therapist	\$89		\$29	• Podiatrist	\$110	\$100	\$29
• Dental Hygienist	\$60		\$29	• Personal Trainer	\$200	\$100	\$29
• Diagnostic Medical Sonographer	\$89		\$29	• Pharmacist	\$140	\$100	\$29
• Dialysis Tech.	\$89		\$29	• Pharmacy Technician	\$89		\$29
• Dietitian	\$89		\$29	• Phlebotomist	\$89		\$29
• EEG Tech.	\$89		\$29	• Physical Therapist	\$157	\$100	\$29
• EKG Tech.	\$89		\$29	• Physical Therapist Assistant	\$80		\$29
• Electrologist	\$89		\$29	• Podiatric Assistant	\$89		\$29
• EMS				• Radiation Therapist	\$89		\$29
➢ Paramedic/Instructor	\$159	\$100	\$29	• Radiologic Tech.	\$89		\$29
➢ Basic/Intermediate/ Instructor Emergency Medical Tech. ²	\$145	\$100	\$29	• Recreation Therapist	\$89		\$29
➢ Volunteer Emergency Medical Technician ³	\$75			• Rehabilitation Assistant	\$80		\$29
• Enterostomal Therapist	\$175	\$100	\$29	• Rehabilitation Therapist	\$157	\$100	\$29
• Exercise Physiologist	\$200	\$100	\$29	• Respiratory Care Provider	\$89		\$29
• Health Educator	\$89		\$29	• Respiratory Therapist	\$89		\$29
• Histologic Tech.	\$89		\$29	• Respiratory Therapist Tech.	\$89		\$29
• Kinesiologist/Kinesiotherapist	\$200	\$100	\$29	• Speech Hearing Therapist	\$79		\$29
• Laboratory Aide	\$49		\$29	• Speech Language Pathologist	\$79		\$29
• Massage Therapist	\$175	\$100	\$29	• Sports Medicine Instructor	\$200	\$100	\$29
• Medical Assistant	\$89		\$29	• Sports Medicine Therapist	\$200	\$100	\$29
• Medical Lab Tech.	\$89		\$29	• Surgical Assistant ⁵	\$89		\$29
• Medical Tech.	\$89		\$29	• Surgical Tech.	\$89		\$29
• Medical Tech. Assistant	\$89		\$29	• X-Ray Machine Operator	\$89		\$29
				• Other Healthcare Aide	\$49		\$29
				• Other (specify) _____			

If no part-time rate is indicated, the full-time rate will be applicable.

¹ Must be an ACA member to be eligible for coverage.

² A person who is working as an EMT-Basic/Intermediate and is studying to be a Paramedic must apply for the EMT-Basic/Intermediate rate.

³ IF YOU RECEIVE A W-2 FORM OR A 1099 FORM FOR YOUR EMT DUTIES, YOU CANNOT APPLY AS A VOLUNTEER.

A volunteer is defined as an EMT-Basic/Intermediate working as-a volunteer and receiving less than \$600 annually as remuneration for those duties. A Paramedic is not eligible for the volunteer rate.

⁴ Must be a certified MT-BC, RMT, CMT or ACMT to be eligible for coverage.

⁵ Excludes Physician Assistants and Physician Extenders.

HPSO PROFESSIONAL LIABILITY INSURANCE PROGRAM

Protect your interests first and foremost with Professional Liability Insurance coverage with limits of up to \$3,000,000 aggregate, up to \$1,000,000 each claim, plus...

LEGAL EXPENSE BENEFIT...

Legal fees will be paid for covered claims, in addition to your liability limits – WIN or LOSE.

LICENSE PROTECTION COVERAGE...

Reimburses you up to \$25,000 aggregate, up to \$10,000 per proceeding for your defense of disciplinary charges and other covered expenses arising out of a covered license protection incident.

ASSAULT COVERAGE...

Covers your medical expenses or reimburses you for damage to your property up to \$25,000 aggregate, up to \$10,000 per incident if you are assaulted at work or while commuting to and from your workplace.

(Assault coverage not available in Texas.)

FIRST AID BENEFIT...

Reimburses you up to \$2,500 aggregate for expenses you incur in rendering first aid to others.

DAMAGE TO PROPERTY OF OTHERS...

Pays up to \$10,000 aggregate, up to \$500 per incident for damage caused accidentally by you to the property of others at your residence or workplace.

DEFENDANT EXPENSE BENEFIT...

Reimburses you up to \$10,000 aggregate for lost wages and covered expenses incurred when you attend a required trial, hearing or proceeding as a defendant in a covered claim.

DEPOSITION REPRESENTATION...

Reimburses you up to \$5,000 aggregate, up to \$2,500 per deposition for attorney fees as a result of your required appearance at a deposition that arises out of professional services.

MEDICAL PAYMENTS...

Pays up to \$100,000 aggregate, up to \$2,000 per person for reimbursement of medical expenses to others injured at your residence or business premises.

PERSONAL INJURY PROTECTION...

Protects you, up to the applicable limits of liability, against covered claims arising from charges of privacy violation, slander, libel, assault and battery, and other alleged personal injuries committed in the conduct of your professional services.

PERSONAL LIABILITY PROTECTION...

Protects you up to \$1,000,000 aggregate for liability damages for covered claims resulting from incidents at your residence, unrelated to your work.

COVERAGE BENEFITS

- **Occurrence-based Coverage**
Protects you regardless of when a claim is filed, provided the policy was in force at the time the covered medical incident occurred.
- **24/7 Worldwide Protection**
24/7 coverage is available worldwide, provided claim is brought against you in the United States, its territories and possessions, Puerto Rico, or Canada.
- **Access your account 24/7 by using our "Virtual Customer Service Representative (VCSR)" at www.hpso.com or by calling 1-800-982-9491.**

DISCOUNTS

- **First-Year Graduate Discount**
If you've graduated within the previous 12 months, you are entitled to a 50% discount off the full-time premium.
- **Retired Discount**
If you are retired but maintain an active license, you may qualify for a 50% discount off the full-time premium with reduced coverages.*
- **A 10% non-cumulative credit will be applied to your annual premium for up to three years if you attend an eligible Risk Management Course.****

*Call 1-800-982-9491 for complete details.

**The course must be 6 contact hours in a subject related to the insured's area of specialization. Must provide a certificate of attendance showing course name, number of hours and course date. Course must have been completed within the last 12 months in order for discount to be applied.

Dedicated to meeting the insurance needs of healthcare professionals for over 25 years!

Questions? Call **HPSO**,
toll-free **1-800-982-9491**



This program is underwritten by American Casualty Company of Reading, PA, a CNA company and is offered through the Healthcare Providers Service Organization Risk Purchasing Group. Coverages, rates and limits may differ in some states. This material is for illustrative purposes only and is not a contract. It is intended to provide a general overview of the products and services offered. Only the policy can provide the actual terms, coverages, amounts, conditions and exclusions. CNA is a service mark and trade name registered with the U.S. Patent and Trademark Office. Healthcare Providers Service Organization is a division of Affinity Insurance Services, Inc.; in NY and NH, AIS Affinity Insurance Agency; in MN and OK, AIS Affinity Insurance Agency, Inc.; and in CA, AIS Affinity Insurance Agency, Inc. dba Aon Direct Insurance Administrators License #0795465.

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F-2477-705



159 East County Line Road • Hatboro, PA 19040-1218
1-800-982-9491 • Fax 1-800-739-8818 • www.hpsso.com

Authorization and Release

I, _____, do hereby authorize Healthcare Providers Service Organization to release any claim information or policy verification regarding my American Casualty Company of Reading, PA's Professional Liability Insurance to:

NAME: (Hospital/Agency) _____

ADDRESS: _____

CITY/STATE: _____

TELEPHONE NUMBER: _____

I understand that this information may also be provided to _____, as the named insured on the policy, and I hereby release American Casualty Company of Reading, PA, a CNA Company, Healthcare Providers Service Organization, Nurses Service Organization, Affinity Insurance Services, Inc. and _____ from any liability as a result of supplying this information to the above mentioned organization or to the Named Insured _____.

INSURED'S PRINTED NAME: _____

POLICY NUMBER: _____

ADDRESS: _____

SIGNATURE AND DATE: _____

Dedicated To Serving The Insurance Needs of Healthcare Providers

Healthcare Providers Service Organization is a division of Affinity Insurance Services, Inc. In NY and NH, AIS Affinity Insurance Agency; in MN and OK, AIS Affinity Insurance Agency, Inc.; and in CA, Aon Insurance Services. In FL, we are not an unaffiliated or independent not-for-profit entity. Affinity Insurance Services, Inc. is a not-for-profit entity.