



Salt Lake City Area Office
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Chicago, IL 60606
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COMPLEMENTARY & ALTERNATIVE MEDICINE

A. General Information

Proposed Effective Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ County: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Physical Location of Business (if different): \_\_\_\_\_

Population within 50 miles: \_\_\_\_\_ Applicant's SS# or FEIN: \_\_\_\_\_

Other Locations Used:

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Please list any other names the business is or has been known by: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Producer's Name: \_\_\_\_\_

Detailed description of business activities (specifically, and by location): \_\_\_\_\_

Applicant is:  Individual  Corporation  Partnership  Joint Venture  Other: \_\_\_\_\_

Is this a new business?  Yes  No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: \_\_\_\_\_

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: \_\_\_\_\_

Annual Payroll: \$ \_\_\_\_\_ Total Number of Employees: \_\_\_\_\_ Full-Time: \_\_\_\_\_ Part-Time: \_\_\_\_\_

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: \_\_\_\_\_

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services?  Yes  No

If yes, please tell us:

Employee Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Business Telephone No.: \_\_\_\_\_

Fax: \_\_\_\_\_ Years with Company: \_\_\_\_\_

Employee's Responsibilities: \_\_\_\_\_

**B. Insurance History**

Who is your current insurance carrier (or your last if no current provider)? \_\_\_\_\_

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor ever had a claim?  Yes  No

Completed Claims and Loss History form attached (REQUIRED)?  Yes  No

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?  Yes  No

If the standard markets are declining placement, please explain why: \_\_\_\_\_

**C. Other Insurance**

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	2	3
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

**D. Desired Insurance**

Per Act/Aggregate

<input type="radio"/>	\$50,000/\$100,000
<input type="radio"/>	\$150,000/\$300,000
<input type="radio"/>	\$250,000/\$1,000,000
<input type="radio"/>	\$500,000/\$1,000,000
<input type="radio"/>	Other: _____

**Self-Insured Retention (SIR):**  \$1,000 (Minimum)  \$1,500  \$2,500  \$5,000  \$10,000

**E. Business Activities**

THE FOLLOWING MUST BE INCLUDED WITH THIS APPLICATION:

- Copy of your current professional liability insurance Declarations Page and currently valued loss experience.
- Copy of your Curriculum Vitae.
- Copies of all advertising that you use, including Yellow Page ads.
- Copy of your business letterhead.
- Supplementary Applications, Claim Information Supplement(s) and additional documentation as needed.

Date of Birth: _____	Number of years at your current location: _____
<b>Type of Practice:</b>	
<input type="checkbox"/> Solo Practice <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company	
<input type="checkbox"/> Partnership (On a separate sheet, please identify partners)	
<input type="checkbox"/> Employed Physician <input type="checkbox"/> Other (specify): _____	

**Medical Training and Practice History**

1. Medical Specialty: Percent of Practice: _____%	2. Medical Sub-Specialty: Percent of Practice: _____%			
	Hospital / College	City & State	Completed?	Year
Medical School			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Internship			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Residency			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Residency			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fellowship			<input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Are you a U.S. citizen?  Yes  No  
 If NO, please provide a copy of documents confirming your status.
4. Are you a Foreign Medical School Graduate?  Yes  No  
 Date of ECFMG certification: \_\_\_\_\_
5. Are you currently Board Certified?  Yes  No  
 Name of Board: \_\_\_\_\_
6. Date you began practicing: \_\_\_\_\_. Within the last five years have your practice characteristics, procedures performed, or business association(s) changed?  Yes  No  
 If YES, please describe details of change on additional sheet.

7. List all primary office locations where you have practiced in the last 10 years. (Use separate sheet if more space is needed).  
 Street Address & City                      County      State      Dates – From / To

8. Please list below all hospitals where you have staff privileges. (If no hospital privileges, attach protocol for patient admission).

HOSPITAL	CITY/ STATE	COUNTY	% OF PRACTICE

9. List the following information for each state where you practice:

STATE	MEDICAL LICENSE NUMBER(S):	DEA LICENSE NUMBER(S):	% OF PRACTICE IN EACH STATE:
			%
			%
			%
			%

10. Please indicate the number of CME hours you have obtained in the past two years: \_\_\_\_\_

11. Indicate your gross annual receipts for the following:

Major Surgery	\$
Minor Surgery	\$
Office Visits	\$
Obstetrics/Gynecology	\$
Plastic Surgery	\$
Other (specify): _____	\$
TOTAL:	\$

12. Identify the percentage of your business operations which are:

Performed by you	%
Performed by your staff	%
Other (specify): _____	%

13. Identify the percentage of your business operations which are:

Performed in your office	%
Performed at a hospital or clinic	%
Other (specify): _____	%

14. Estimate total gross receipts from all operations for the next 12 months:

Major Surgery	\$
Minor Surgery	\$
Office Visits	\$
Obstetrics/Gynecology	\$
Plastic Surgery	\$
Other (specify): _____	\$
<b>TOTAL:</b>	<b>\$</b>

15. Estimate total annual gross receipts from all business operations for the next 12 months:

\$ \_\_\_\_\_

**F. Office Staff**

1. Do you employ, contract with, or supervise any physician(s) or surgeon(s)?  Yes  No

If YES, advise of number and attach current certificate(s) of insurance.

2. Do you employ, contract with or supervise any non-physician health care extenders?  Yes  No

If YES, enter information below:

	NUMBER		NUMBER
LPN		Certified Nurse Midwife (CNM)	
RN		Pharmacist	
CNA		Laboratory Technician	
Physician Assistant:		Other (please describe):	

**G. Practice Information**

1. Please indicate:

a. Average number of patients seen each week: \_\_\_\_\_

b. Average number of patients seen each month: \_\_\_\_\_

c. Average number of patients seen each year: \_\_\_\_\_

d. Percentage of locum tenens work: \_\_\_\_\_%

2. Weekly practice hours: \_\_\_\_ to \_\_\_\_

3. Please list any medical association membership(s): \_\_\_\_\_  
 \_\_\_\_\_

4. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center?  Yes  No

If YES, please describe on separate sheet.

5. Do you perform abortions?  Yes  No

If YES, please tell us:

a. Indicate number each month: \_\_\_\_\_ Type:  Elective  Therapeutic

b. Where performed? (Check all that apply)  Office  Hospital  Other (Explain on separate sheet).

c. Maximum Gestation Age? \_\_\_\_\_

6. Does your practice include the following? Check all that apply

No Surgery

No surgery, with the exception of incision of sebaceous boils and cysts. Incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns, and umbilical and urethral catheterization.

Minor Surgery

Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive). *No general anesthesia.*

If YES, indicate the average number of minor surgeries performed per week:

Major Surgery

Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen, or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It also includes removal of tumors (except skin tumors), reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation using general anesthesia.

If YES, indicate the average number of major surgeries performed per week:

Obstetrics

If checked, please indicate annual:

Number of vaginal deliveries: \_\_\_\_\_

Number of cesarean sections: \_\_\_\_\_

Number of Home or Non-Hospital Deliveries: \_\_\_\_\_  
(Please describe on separate sheet)

Elective Plastic Surgery

Please describe procedures and annual number performed on separate sheet.

7. Do you perform any of the following procedures?

Acupuncture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney, Ureter, and Bladder Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amniocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Laparoscopies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angiography?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Laser Treatments via Endoscope?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arteriography?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Forceps Deliveries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting in surgery on other than your own patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignant Lesion Surgical Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting in surgery on your own patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mastoidectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amputations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Middle or Inner Ear Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blepharoplasty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mid-Forceps Delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Augmentation or Reduction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	MOHS Micrographic Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breech Deliveries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myleography?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Catherizations? (Right Heart)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Needle Biopsies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical Biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical Cautery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Norplant Insertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chelation Therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity/Weight Control Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Peels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Office Gynecology?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cleft Lip or Palate Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oophorectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Trials?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Open Reduction of Fractures? (Plating & Pinning)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Closed Reduction of Fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ophthalmologic Surgery? (Laser or other)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collagen Lip Injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colonoscopy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Surgery? (Including Spinal Surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Complex Flaps and Grafts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Surgery? (No Spinal Surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Conization of Cervix?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oloplasty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Culdocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pedicia Screw Insertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnostic Radiology?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Augmentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dilation and Curetage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electroshock Therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pericardiocentesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endomeinal Biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Eyeliner Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endoscopic Retrograde / Cholangiopancreatography?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy Care into Second Trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Episiotomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy Care into Third Trimester?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experimental Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostatectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastric Bubble Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy? (Radium Implants)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hair Transplant Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reconstructive Plastic Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Risk Pregnancies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scalp Reduction Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperbaric Chamber Treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sex Change Operations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sterilization Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Interphalangeal Joint Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suction Lipectomy Procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hysterectomies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombectomy of Arteries and Veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toxemia Management?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herbal Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Traditional Chinese Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anti-Aging Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon Hydrotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reiki	<input type="checkbox"/> Yes <input type="checkbox"/> No
Magnet Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hormone Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reflexology	<input type="checkbox"/> Yes <input type="checkbox"/> No	Carboxy Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Massage Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	CAM Modalities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Auriculotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bariatrics	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bio-oxidative Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sclerotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hydrogen Peroxide Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperbaric Oxygen Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nevral Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Botanical Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Naturopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	UV Blood Irradiation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ayurvedic medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Biofeedback	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chiropractic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Homeopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked?  Yes  No  
If YES, please describe on separate sheet.
9. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked, or voluntarily surrendered?  Yes  No  
If YES, please describe on separate sheet.
10. Are you now, or have you ever been involved in any professional liability claim or suit?  Yes  No
11. Are you aware of any circumstances that might lead to a claim or suit?  Yes  No  
If YES, has this information been reported to a current or prior insurance carrier?  Yes  No
12. Has your professional liability insurance ever been refused, cancelled, or non-renewed?  Yes  No  
If YES, please explain on a separate sheet. (*Response not required in the state of Missouri*).
13. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency?  Yes  No  
If YES, please explain on a separate sheet.
14. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness?  Yes  No
15. Have you ever been charged with, or convicted of a crime other than minor traffic violations?  Yes  No  
If YES, please explain on a separate sheet.
16. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s), or a state licensing authority?  Yes  No  
If YES, please explain on a separate sheet.
17. Do you own or operate a Laboratory?  Yes  No  
If yes,
- a. Does the laboratory provide services solely for your patients?  Yes  No
- b. If not limited to your patients, please explain on separate sheet.
18. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs?  Yes  No  
If YES, please explain on a separate sheet.
19. Do you now or have you ever treated prisoners in a state, federal, or any correctional institution?  Yes  No
20. Do you practice as a company doctor (excluding treatment of workers compensation patients)?  Yes  No  
If YES, please answer:
- a. What products are manufactured by the company? \_\_\_\_\_  
\_\_\_\_\_
- b. Do you review or establish plant/employer safety standards?  Yes  No

c. Do you provide medical treatment to company employees?  Yes  No

Company Name: \_\_\_\_\_ Location: \_\_\_\_\_

21. Does your practice include weight reduction/control by other than diet and exercise?  Yes  No  
If YES, please complete the information below or attach separate sheet if needed:

a. What percentage of patients are treated exclusively for weight control? \_\_\_\_\_

b. List injections used for weight control: \_\_\_\_\_

c. If you prescribe or dispense drugs for weight control, please list drugs and describe protocols:

d. Describe any other weight control procedure, including surgery, that you provide to your patients:

22. Do you authorize any collection agency, at its own discretion, to file a claim or suit?  Yes  No

23. Do you work in an Emergency Room for other than maintaining hospital privileges?  Yes  No  
Please indicate the average number of hours you work in the Emergency Room each month:

24. Are you a sports team physician or health care provider?  Yes  No  
If YES, check all that apply:  High School  College  Professional  Other

Name and location of teams: \_\_\_\_\_

25. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director, or are you under contract to provide professional services, at any Nursing Home or similar facility?  Yes  No

If YES, describe percentage of your practice and name(s) of nursing home facilities: \_\_\_\_\_

26. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director of a hospital or hospital department, sanitarium, ambulatory care clinic with bed and board facilities, health maintenance organization, preferred provider organization, or any other business enterprise?  Yes  No

If YES, please identify, provide address, and explain details on a separate sheet.

27. Do you serve in a 'Gatekeeper' capacity—that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization?  Yes  No

If YES, please advise of percentage of your practice devoted to Gatekeeper activity: \_\_\_\_%

28. Do you engage in tele-medicine activity?  Yes  No  
If YES, please describe on separate sheet.

29. Do you prescribe drugs or provide diagnosis via the Internet?  Yes  No  
If YES, please describe on separate sheet.

30. Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)?  Yes  No  
If YES, please describe on separate sheet.

**H. Anesthesia / Office Surgery**

1. Do you perform or assist in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis?  Yes  No

If YES, please complete the questions below:

a. Description and annual number of procedures: \_\_\_\_\_

\_\_\_\_\_

b. Annual number of procedures with: General Anesthesia: \_\_\_\_\_

Spinal or Caudal Anesthesia: \_\_\_\_\_

Other: \_\_\_\_\_

c. Anesthesia administered by: \_\_\_\_\_

d. Distance to nearest hospital: \_\_\_\_\_

e. Description of life-saving equipment/supplies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: \_\_\_\_\_

Applicant:

Dated: \_\_\_\_\_

Agent/Broker:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name