# Application Guide

Protects your interests first and foremost.

HPSO 159 East County Line Road Hatboro, PA 19040-1218
fax: 1-866-234-6372

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

A3SA2HFX

***PLEASE PRINT CLEARLY AND COMPLETE THE FOLLOWING:***

Name: _____ Day Telephone #: _____

Home Address: _____ Night Telephone #: _____

City: _____ Fax #: _____

State: _____ Zip code: _____ E-mail: _____

Fill out contact information here.

**Please answer ALL questions and SIGN and DATE this application. Incomplete applications cannot be processed.**

1. Please find you profession on the profession list (page 3) and write it in below. Next, enter your state of residency. Part time is 24 hours or less per week.

**Choose from these 4 professions:**
- Private Duty Aide
- Companion
- Home Health Aide
- Home Care Aide

(Write this again at the bottom of page 3.)

Profession: _____

☐ **Full Time**
☐ **Part Time**

If you work more than 24 hours per week, check **Full Time**

SKIP ☐ **Recent Graduate** If you have graduated [illegible] full-time coverage, you are eligible for a 50% discount off your premium.

SKIP 1b. ☐ **Employed:** you provide services on behalf of an entity you do not own, receive a W-2 form from your employer and pay your own insurance premium.
If you are employed, please provide the following: Name of employer: _____ City: _____ State: _____

CHECK 1c. ☑ **Self-Employed:** you provide services on behalf of an entity you do not own as an independent contractor and pay self-employment taxes using a 1099 form.
**OR, your employer pays your insurance premium.** If you are incorporated with or without employees, please contact your broker for more information.

SKIP 1d. ☐ **Student:** you are a first-time student who does not currently hold a healthcare license or certification. If you currently hold a license or certification as a healthcare provider, but are a student in another healthcare profession, please contact your broker.

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

| | | | | |
|---|---|---|---|---|
| ☐ Ambulatory Care Facility (1) | ☐ Home Health (05) | ☐ Nursing School (09) | ☐ Surgicenter (13) | ☐ Research Center (18) |
| ☐ Comm. Health Agency (02) | ☐ Hospice (06) | ☐ Prison (10) | ☐ My own premises (14) | ☐ Industry (19) |
| ☐ Doctor's Office/Clinic (03) | ☐ Hospital (07) | ☐ School (11) | ☐ Outpatient Facility (16) | ☐ Fire/Rescue Station (20) |
| ☐ HMO/PPO (04) | ☐ Nursing Home (08) | ☐ Staffing Agency (12) | ☐ Health & Wellness Facility (17) | ☐ Rehab Facility (21) |
| ☐ Other (15) _____ | | | | |

**Check 'Other' and write one of the following options:**
- Senior Living Community
- Assisted Living Community
- Skilled Nursing

3. Social Security #: ___ - ___ - ___ Date of Birth: ___ / ___ / ___ (MONTH / DAY / YEAR)

4. Requested Effective Date: ___ / ___ / ___ (MONTH / DAY / YEAR) (Must be within 60 days from the date we receive your application. If date indicated is prior to receipt date or if not filled out, the effective date will be the receipt date.)

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

6. 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

7. 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

8. 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 6, 7 or 8, please provide complete details on a separate sheet of paper and attach to application.)**

**Insurance Agent: Michael J. Loughran Iowa License# IA241616; Florida License# A158896**

**Payment Options:**

☐ **Enclosed is my check. (Payable to: HPSO)** ☐ **Charge my credit card:** ☐ AMEX ☐ Visa ☐ MasterCard ☐ Discover

Card #: _____ Expiration Date: ___ / ___

***All applicants must add a Healthcare Providers Service Organization Purchasing Group Membership Fee ($3.00)** Residents of KY, NJ and WV must first add a state mandated surcharge to your base premium (KY: 1.8, NJ: 0.65%, WV: 0.55%). To calculate your total amount due, please add your base premium, state surcharge (if applicable) and membership fee. **If you are paying by credit card,** your card will be charged as detailed above.

**Agent/Broker Information:**

**Agency Name:** _____ **Contact Name:** _____

**Address** _____ **City:** _____ **State:** ____ **Zip:** _____

**Email:** _____

**Agency Name:** BIN Insurance Holdings, LLC.
**Contact Name:** Brian Alban
**Address:** 30 N LaSalle Ste. 2500
**City:** Chicago
**State:** IL
**Zip:** 60602
**Phone:** 800.688.1984
**Fax:** 855.804.8443

e in ink. 3. Send **all pages** of the application. We cannot process if **all pages** are not received.

**Continue to next page.**

3PP0115

# Application Guide (page 2)

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 guidelines. I have not withheld information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete this insurance. It is agreed that this Application shall be on file with the Company and that it shall be deemed to be attached to and made part of the policy, if issued, as if physically attached to the policy. I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my insurance coverage. This application will be the basis of the contract if a Certificate of Insurance is issued. Once approved, I understand that there is no coverage in force until the premium is paid in full. I understand that a state mandated surcharge will be added to my annual premium if I am a resident of KY(1.8%), NJ (0.65%) or WV (0.55%). I have read and consent to the compensation terms below.

**FRAUD NOTICE - WHERE APPLICABLE UNDER THE LAW OF YOUR STATE**

**All other States:** 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 District of Columbia residents only:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information, materially related to a claim, was provided by the applicant.) **(For Florida residents only:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) **(For Kentucky residents only:** 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 insurance act, which is a crime.) **(For Louisiana residents only:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) **(For Maine residents only:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.) **(For Maryland residents only:** Coverage may be terminated or the premium recalculated due to a change in a material risk factor during the 45-day underwriting period that begins on the effective date of the first policy period.) **(For New York residents only:** 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 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 Oklahoma residents only:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) **(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 and Washington residents only:** 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. Penalties include imprisonment, fines and denial of insurance benefits.) **(For Vermont residents only:** 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 may be a crime and may be subject to civil fines and criminal penalties.)

**Please Print Name** _____

**Applicant Signature** X _____ Date: ___ / ___ / ___ (MONTH / DAY / YEAR)

Sign and date here.

**This application must be fully completed, signed and dated in ink. We will issue your certificate of insurance upon approval.**



HPSO
Healthcare Providers Service Organization



**The Consulting Services Liability Endorsement**

Are you consulting, teaching or training in addition to providing direct patient care?

This professional liability policy provides coverage if there is an act, error or omission in providing professional services which results in injury. However, economic or financial loss, through your participation in activities such as public speaking or providing expert testimony, typically would not be covered by your professional liability policy. It's a risk you don't have to take. The Consulting Services Liability Endorsement provides coverage for when you use your professional skills and knowledge in settings that do not involve direct treatment of clients. You can add this valuable protection to your new policy for only $25 a year.

For more information, visit www.hpso.com/consult

**COMPENSATION and OTHER DISCLOSURE INFORMATION**

Healthcare Providers Service Organization, a registered trade name of Affinity Insurance Services, Inc., exclusively offers the HPSO Program as an agent of CNA and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

Affinity Insurance Services Inc. is an insurance producer licensed in your state. Insurance producers are authorized by their license to advise insurance purchasers about the terms and conditions of particular insurance contracts and to assist in the sale and binding of such policies. Compensation will be paid to the producer by the insurer and/or a third party based on the insurance contract the producer sells. Such compensation may vary depending on a number of factors, including the insurance contract(s) and the insurer(s) the purchaser selects. In addition, Affinity may charge a fee for administrative services. Your signature on this application, or your authorization for payment, is your acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Affinity. You may obtain additional information about compensation received or expected to be received by Affinity regarding the CNA quote on any alternative quotes presented to the purchaser by Affinity, by contacting member services at 1-800-982-9491. In addition, premiums paid to Affinity for remittance to insurers, refunds and claim payments paid to Affinity by insurance companies are deposited into fiduciary accounts in accordance with applicable insurance laws. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit. Our liability to you, in total, for the duration of our business relationship for any and all damages, costs, and expenses (including but not limited to attorneys' fees), whether based on contract, tort (including negligence), or otherwise, in connection with or related to our services (including a failure to provide a service) that we provide in total shall be limited to the lesser of $6,000,000 or the singular annual limit of the policy of insurance procured by us on your behalf from which your damages first arise. This liability limitation applies to you, our client, against Affinity, and its parent(s), affiliates, subsidiaries and their respective directors, officers, employees and agents (each an "Affinity Group Member"). Nothing in this liability limitation section implies that any Affinity Group Member owes or accepts any duty or responsibility to you. If you assert any claims or make any demands against us or any Affinity Group Member for a total amount in excess of this liability limitation, then you agree to indemnify Affinity for any and all liabilities, costs, damages and expenses, including attorneys' fees, incurred by Affinity or any Affinity Group Member that exceeds this liability limitation. Aon Corporation, our parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at http://www.aon.com/market_relationships for a current listing of such relationships.
A full copy of the Affinity compensation and other disclosure information can be found at www.hpso.com/disclosure

**Contracts and Agreements**

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit **http://www.aon.com/market_relationships** for more detail on these agreements.

# Application Guide (page 3)

Print Name: _____

Please select your profession from below, and write in on page 1.

- ☐ Art Therapist
- ☐ Athletic Trainer
- ☐ Audiologist
- ☐ Bio-med/Biotechnology
- ☐ Bio-med Tech
- ☐ Blood Bank Tech
- ☐ Central Services Tech
- ☐ Certified Medical Asst
- ☐ Certified Medical Aid
- ☐ Child Development
- ☐ Chiropractic Asst
- ☐ Chiropractic Technician
- ☐ Circulation Tech
- ☐ Clinical Lab Tech
- ☐ Coding/Medical Billing
- ☐ Community Health Asst
- ☐ Community Health Tech
- ☐ Corrective Therapist

**Counselor**

- ☐ Alcohol/Drug
- ☐ Marriage/Family
- ☐ Pastoral/Guidance
- ☐ School
- ☐ Wellness
- ☐ Clinical/Rehab/Mental Health
- ☐ Other (write below & on page 1)

_____

_____

- ☐ Dance Therapist
- ☐ Dental Asst
- ☐ Dental Hygienist
- ☐ Dental Lab Tech
- ☐ Diagnostic Medical
- ☐ Dialysis Tech
- ☐ Dietician
- ☐ EEG Tech
- ☐ EKG Tech
- ☐ Electrologist
- ☐ EMS-Paramedic
- ☐ EMS-Volunteer
- ☐ EMS-First Responder
- ☐ Enternostomal Therapist
- ☐ Exercise Physiologist
- ☐ Gerontology
- ☐ Health Care Services/Admin
- ☐ Health Educator
- ☐ Histologic Tech
- ☐ Home Health Aide
- ☐ Hospital Pharmacy Tech
- ☐ Kinesiologist/Kinesiotherapist
- ☐ Laboratory Aide
- ☐ Laboratory Tech
- ☐ Mammography Tech
- ☐ Medical Assistant
- ☐ Medical Lab Tech
- ☐ Medical Tech Assistant
- ☐ Medical Records Admin
- ☐ Medical Technologist
- ☐ Medical Preparation Tech
- ☐ Mental Health Tech
- ☐ Mental Retardation Work
- ☐ MRI Tech
- ☐ Music Therapist
- ☐ Nuclear Medical Tech
- ☐ Nurse's Aide
- ☐ Nursing Assistant
- ☐ Nutritionist
- ☐ Occupational Therapist
- ☐ Occupational Therapist Asst
- ☐ Optometry Tech/Asst
- ☐ Orthopedic Asst
- ☐ Orthotics/Prosthetics
- ☐ Patient Care Asst
- ☐ Patient Care Technician
- ☐ Pedorthist
- ☐ Perfusionist
- ☐ Pharmacist
- ☐ Pharmacist Asst/Tech
- ☐ Phlebotomist
- ☐ Physical Therapist
- ☐ Physical Therapist Asst
- ☐ Physician Assistant
- ☐ Podiatric Asst
- ☐ Polysomnographer
- ☐ Psychological Therapist
- ☐ Radiation Therapist
- ☐ Radiologic Tech
- ☐ Recreation Therapist
- ☐ Rehabilitation Assistant
- ☐ Rehabilitation Therapist
- ☐ Renal Dialysis Tech
- ☐ Respiratory Therapist
- ☐ Social Worker
- ☐ Sonographer
- ☐ Speech Hearing Therapist
- ☐ Speech Language Pathologist
- ☐ Sports Medicine Instructor
- ☐ Sports Medicine Therapist
- ☐ Surgical Assistant
- ☐ Surgical First Asst
- ☐ Surgical Technologist
- ☐ Ultrasound Technician
- ☐ Vascular Technician
- ☐ X-Ray Technician
- ☐ Other (write below & on page 1)

_____

_____

**Write your profession here:**

**(same as page 1)**