



**For California Only**  
**Individual Professional Liability Insurance Occurrence Application**  
**For members of the International Somatic Movement and Education Therapy Association**  
**Mail To: 159 East County Line Road, Hatboro, PA 19040-1218 • Toll-Free #: 1-888-273-4610 • Fax #: 1-800-739-8818**

PLEASE PRINT CLEARLY AND COMPLETE THE FOLLOWING:

FIT-F6WWA06

Name: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

Day Telephone #: (\_\_\_\_) \_\_\_\_\_  
 Night Telephone #: (\_\_\_\_) \_\_\_\_\_  
 Fax: (\_\_\_\_) \_\_\_\_\_  
 E-mail: \_\_\_\_\_  
 ISMETA membership number: \_\_\_\_\_

**YES! I want individual Professional Liability Insurance with limits of up to \$3,000,000 aggregate, up to \$1,000,000 each claim (17).**  
 Coverage is not available if you work as a sport team coach; provide fitness services to professional athletes; or provide salon or cosmetic procedures or spa services. Coverage does not extend to recommendation, production, promotion, solicitation, testing, selling or manufacture of vitamins, minerals, herb supplements and nutritional supplements.

**My initials indicate that: I am not a sport team coach; do not provide fitness services to professional athletes, salon or cosmetic procedures or spa services.**

INITIAL HERE

1. Please indicate your classifications or certifications. (Part-time is 24 hours or less per week):

I am a:  Somatic Movement Educator  Somatic Movement Therapist

<b>Employed F/T</b>	<b>Employed P/T</b>	<b>Self-employed F/T</b>	<b>Self-employed P/T</b>	<b>Student</b>
\$168 <input type="checkbox"/>	\$100 <input type="checkbox"/>	\$346 <input type="checkbox"/>	\$173 <input type="checkbox"/>	\$29 <input type="checkbox"/>

Recent Grad<sup>1</sup> – Eligible for a 50% discount off the full-time rate.

Name of School: \_\_\_\_\_ Graduation Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<sup>1</sup>Must have graduated within the last 12 months to qualify.

Do you need Prior Acts Coverage? (If so, you must provide the Retro Date of your current policy, found on the Declarations Page).

Yes, I need Prior Acts Coverage. My retro date is \_\_\_\_/\_\_\_\_/\_\_\_\_ (If Retro Date is applicable, you must provide your current carrier Declarations Page.)

If requesting prior acts, please include a copy of your claim loss data from your previous insurance carrier.

No, I do not need Prior Acts Coverage, I have read and understand "Important Notice About Prior Acts" on reverse side. INITIAL HERE \_\_\_\_\_

Enter your Annual Premium \_\_\_\_\_ (Refer to reverse side for rates)

1a. 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. If you are incorporated with or without employees, please call 1-888-288-3534 for more information.

2. I work in (check all that apply):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> My own premises (14)            | <input type="checkbox"/> Rehab Facility (21)  | <input type="checkbox"/> Personal Training Studio (23) | <input type="checkbox"/> Yoga Studio (25)   |
| <input type="checkbox"/> Health & Wellness Facility (17) | <input type="checkbox"/> Health Club/Gym (22) | <input type="checkbox"/> Pilates Studio (24)           | <input type="checkbox"/> Client's Home (26) |
| <input type="checkbox"/> Other (15) _____                |   |  |   |

3. Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4. Requested Effective Date of Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_ (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 the ISMETA? (You must be a member of ISMETA to be eligible for this coverage.) .....  Yes  No

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  Discover  MasterCard  Visa  
 Bill me for the annual premium. Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please add a state mandated surcharge to your annual premium. For NJ residents add 1.6%; for WV residents add 0.55%; for FL residents add 2.91%**

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 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 (1.6%), WV (0.55%) or FL (2.91%). I have read and consent to the compensation terms on the reverse side.

**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: and subjects such a person to criminal or civil penalties.) (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, Pennsylvania, 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 of Affinity Insurance Services, Inc.; in CA (License #0795465), MN & OK, AIS Affinity Insurance Agency, Inc.; and in NY, AIS Affinity Insurance Agency.

**QUESTIONS? Call Toll-Free 1-888-273-4610 • Fax 1-800-739-8818**

**Please see the reverse side for compensation disclosure information.**



## IMPORTANT NOTICE CONCERNING PRIOR ACTS – PLEASE READ

If you are currently insured under a claims-made policy, it is important that you continue your coverage without interruption when moving to a new policy. By providing HPSO with the Retroactive Date or “Retro Date” of your expiring policy, upon approval of your application, your new policy will provide you with continuous coverage. This means that any claim that might occur on or after your Retro Date will be covered under your new policy. If you do not provide your current Retro Date on this application, and do not elect to purchase Extended Reporting Period coverage from your former insurer (“tail coverage”), your previous claims-made coverage will lapse. It will no longer respond to any claims that may arise for that original policy period – and neither will your new policy. This could leave you completely unprotected or “bare” for the duration of that original policy.

### Determine Your Rates

If you have been insured under a claims-made policy and wish to continue your coverage without interruption you must include a copy of your current Declarations Page with this application. Please enter the Retro Date of your current policy (found on the Declarations Page), and the requested effective date of your new policy, on the front of the application where indicated. To determine the appropriate rate, first note the number of years that have elapsed between the dates you provided above. Fractional years of six months or more are rounded UP; less than six months rounded to the next lower year. Once you’ve calculated the correct number of years, add 1 to this total to represent the current year, and this number is the basis for your coverage. If the total is 4 years or more, you would pay the “Mature” rate (4+ years) listed on the chart below. Totals of less than 4 years pay the appropriate premium listed in the matching column. Please note the total premium you’ve selected on the form of this application where indicated.

If you have any questions or need help with this application, or if you would like information on Prior Acts coverage for services performed before the effective date of this policy, please call 1-888-273-4610 for assistance.

### Rates WITHOUT Prior Acts

Soamtic Movement Eduactor or Somatic Movement Therapist	<b>Employed F/T</b> \$168	<b>Employed P/T</b> \$100	<b>Self-employed FT</b> \$346	<b>Self Employed P/T</b> \$173	<b>Student</b> \$29
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**NOTE:** Charge for prior acts is a **one-time charge**. For example, if you are a Full Time Employed Licensed Alexander Technique Instructor with 1 year prior acts coverage, you will be paying \$326 (\$168 plus \$158 for 1 year prior acts coverage). At renewal, you will no longer pay for prior acts coverage. Your premium at renewal will be the current premium.

Part time rates with prior acts not available.

### Rates WITH Prior Acts

Soamtic Movement Eduactor or Somatic Movement Therapist		<b>Employed F/T</b>	<b>Self-employed F/T</b>
	1 Year	\$326.00	\$671.00
	2 Years	\$407.00	\$837.00
	3 Years	\$444.00	\$913.00
	4+ Years	\$464.00	\$955.00

## *Questions Regarding your Coverage?*

**Call us Toll-free at 1-888-273-4610**

**Email us at [service@hpso.com](mailto:service@hpso.com)**

**Find us on the web at [www.hpso.com](http://www.hpso.com)**

### Compensation and Other Disclosure Information

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

As compensation for the services described above, Affinity receives 20% of your paid premium as commission for marketing the program and 20% for administrative services. In addition, Affinity receives \$0.48 annually per paid policy as commission for claim handling for the License Protection coverage extension of the professional liability insurance policy. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer and there will be no other fees or charges to you.

Your signature on your application, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Affinity.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. 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 in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. 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](http://www.aon.com/market_relationships) for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

### 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](http://www.aon.com/market_relationships) for more detail on these agreements.