XINSURANCE

8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-585-2853 • Fax 877-585-2854

PERSONAL PROFESSIONAL LIABILITY APPLICATION

Date: _____

A. General Information

1. Applicant (full legal name of person to be insured): _____
2. Date of Birth: _____
3. Resident Street Address: _____
4. City: _____ State: _____ Zip: _____
5. Telephone Number: _____ Email: _____
6. Employer: _____
7. Annual Income from Employer: _____ Other Income: _____
8. Source of Other Income: _____
9. Annual volunteer days per year: _____
10. Please list details for all insurance policies issued to you or your practice:

Type:	Carrier:	Policy Number:	Desc. of Coverage:
Homeowners:			
Auto:			
Motorcycle:			
Malpractice:			
Professional:			
Other:			

B. General Information For Medical Practitioners

Professional Designation:

☐ M.D. ☐ D.O. ☐ D.P.M.

Primary Practice – Street Address:

(If more than one location, list on additional sheet)

Medical Training and Practice History

Medical Specialty: Percent of Practice: _____%		Medical Sub-Specialty: Percent of Practice: _____%		
	Hospital / College	City & State	Completed?	Year

Medical School			☐ Yes ☐ No	
Internship			☐ Yes ☐ No	
Residency			☐ Yes ☐ No	
Additional Residency			☐ Yes ☐ No	
Fellowship			☐ Yes ☐ No	

1. Are you currently Board Certified? ☐ Yes ☐ No
   Name of Board: _____

2. Date you began practicing: _____

3. Please identify all types of services for which you are requesting coverage: _____

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

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

5. Please list any medical association membership(s): _____

6. 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.

7. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? ☐ Yes ☐ No

8. 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.

9. Are you a sports team physician or health care provider on a volunteer basis? ☐ Yes ☐ No
   If yes, check all that apply: ☐ High School ☐ College ☐ Professional ☐ Other: _____
   If no, and you would like coverage for your professional liability in the above capacity, please see our Professional Liability application available at www.xinsurance.com

10. Name and location of teams referenced above: _____

11. 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.

12. Number of estimated patient encounters and patient tests in the last 12 months:
    (Note: "patient encounters" refers to number of visits – not number of patients)
    Patient encounters: _____ Patient Tests: _____

13. Number of estimated patient encounters and patient tests in the next 12 months:
    (Note: "patient encounters" refers to number of visits – not number of patients.)
    Patient encounters: _____ Patient Tests: _____

C. Childcare/Adult Care

1. List ages for which care is provided: _____
2. Are children/adults with physical or emotional disabilities cared for? ☐ Yes ☐ No
   If yes, please explain. _____
   Identify types of disabilities: _____
3. Certifications or licenses held: _____

D. Other Professional

1. Describe in detail operations and services you provide and would like insurance coverage for: _____

2. Certifications and/or licenses held: _____

E. Hobbies and/or Moonlighting:

1. Please list your hobbies and/or moonlighting operations: _____

2. Would you like coverage for any of the above-referenced hobbies/moonlighting? ☐ Yes ☐ No
   If yes, which ones? _____

F. Limits of Liability

Please select limits:

☐ 25/50/100 ☐ 50/100/200 ☐ 100/200/400 ☐ 150/300/600 ☐ Other: _____

If you desire higher limits, please complete either the Professional Liability, Doctors and Surgeons, or Wrongful Acts application available on www.xinsurance.com.

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

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: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print name	Print name