



505 Cloverdale Road, Suite 104  
 Montgomery, AL 36106  
 Return to: notifications@inspirien.net

### Application for Excess Liability

#### Section 1 - Applicant Information

Corporate Name \_\_\_\_\_

#### Section 2 - Limits of Liability

Coverage Effective Date

From: \_\_\_\_\_ To: \_\_\_\_\_

Select Limits - Check One (in millions)  \$1  \$3  \$5  Other \_\_\_\_\_

Enter retroactive date desired \_\_\_\_\_

#### Section 3 - Primary Coverage

List below all primary liability policies for which coverage is desired

Type	Company	Limit	Premium	Policy Period		Policy Number
				Month/Year	Month/Year	
Professional Liability				Month/Year	Month/Year	
General Liability				Month/Year	Month/Year	
Commercial Auto Liability				Month/Year	Month/Year	
Employers Liability				Month/Year	Month/Year	
Other				Month/Year	Month/Year	
Other				Month/Year	Month/Year	
Other				Month/Year	Month/Year	

List the number and type of owned or leased vehicles:

Total Number of Vehicles \_\_\_\_\_ Owned \_\_\_\_\_ Leased \_\_\_\_\_ Non-owned \_\_\_\_\_  
 Number of Private Passenger Vans \_\_\_\_\_ Light Trucks/Service Vans \_\_\_\_\_ Medium Truck \_\_\_\_\_  
 Heavy Truck \_\_\_\_\_ Ambulance \_\_\_\_\_ Bus (1-8 Passenger) \_\_\_\_\_  
 Bus (9-20 Passenger) \_\_\_\_\_ Bus (21+ Passenger) \_\_\_\_\_ Other \_\_\_\_\_

Provide Estimates of:

Annual Payroll \_\_\_\_\_ Annual Receipts \_\_\_\_\_ Number of Employees \_\_\_\_\_

Locations: What is the square footage of all covered locations? \_\_\_\_\_

## Section 4 – Previous Excess/Umbrella Insurance Carriers

List all excess/Umbrella policies for the past five years

Limits	Company	Policy Period		Policy Premium	Retroactive Date
		Month/Year	Month/Year		
		Month/Year	Month/Year		
		Month/Year	Month/Year		
		Month/Year	Month/Year		
		Month/Year	Month/Year		
		Month/Year	Month/Year		
		Month/Year	Month/Year		

Have any claims ever been made against you?  Yes  No

Do you know of any pending claims, incidents, activities include any request for patient records that might give rise to a claim in the future?  Yes  No

Have you reported all claims or activities about to your prior insurance carrier?  Yes  No

If no, identify each claim or incident that has not been reported on a separate sheet of paper and attach to your application.

Has any insurance company ever declined, failed to renew, conditionally renewed, restricted, or cancelled your professional liability policy?  Yes  No

If yes, please list company, date and reason for this action below

Company \_\_\_\_\_ Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Company \_\_\_\_\_ Date \_\_\_\_\_ Reason \_\_\_\_\_

### PLEASE ATTACH THE FOLLOWING

Proof of coverage and a minimum of 10-year loss history for the following policies (unless the underlying policy is written under Inspirien)

- Professional Liability
- General Liability
- Employers Liability
- Commercial Auto Liability

## State Disclosure Addendum

### Read Carefully Before Signing

The statements in this application, together with any supplemental applications, attachments and any other information submitted to the company in connection with this application will be referred to as the "policy application."

### Representations as to accuracy of application, the authority of person signing, and applicant's obligation to supplement information

By signing below, I represent and certify: (i) that the information contained in the policy application is true and accurate; (ii) that I have made all reasonable efforts to investigate the accuracy of the information provided in the policy application and to obtain such information from all persons and entities to be insured by the requested policy as is necessary to provide true and accurate information in the policy application; and (iii) that I am duly authorized to sign this policy application on behalf of all persons and entities to be insured by the requested insurance and that I have carefully read this policy application.

I acknowledge that obtaining the requested insurance, including any renewals of the requested insurance, is conditioned upon providing true and accurate information in this policy application, and any such insurance that may be issued will be based upon the company's reliance on the information provided in the policy application. I also agree and understand that this policy application shall be the basis of the contract should a policy be issued, and that this policy application will be deemed to be attached to and part of such policy and any renewals of such policy, if issued. Further, if any information in this policy application is misleading, incomplete or false, the company may void the insurance issued pursuant to this policy application to the extent permitted by applicable law.

I agree that I will immediately notify the company in writing of any material change in the information provided in this policy application that may occur before the effective date of the requested insurance or before any renewal of the requested insurance. I understand that if I fail to provide such notice, the company may void the insurance issued pursuant to this policy application or any renewal of the requested insurance. I understand that, to the extent permitted by applicable law

(and except as may be prohibited under Montana and/or Oregon law), the company may in its sole discretion modify or withdraw any quotation or agreement to bind insurance in the event of any material change in the information provided in this policy application.

#### **No Obligation to Issue or Purchase Insurance**

I understand that the policy application is not a binder of insurance. Accepting the policy application does not bind the company to issue, or me to purchase, the requested insurance regardless of whether I have made payment, in whole or in part, for the requested insurance or whether the company has deposited such payment. I understand that the requested insurance shall not be effective until I have paid a deposit to the company in the amount invoiced by the company, regardless of whether or not a policy or any renewals of such policy have been issued.

#### **Authorization to Obtain Information**

The company is hereby authorized to obtain full information from any liability insurer, healthcare insurer, hospital, healthcare provider, medical association or society, board of medical examiners, governmental agency, attorney or other person or entity concerning: (i) any medical malpractice claim, suit, licensing board proceeding, credentialing proceeding, disciplinary action or any other civil or criminal action asserted against or relating to the professional conduct of any person or entity to be covered by the requested insurance; (ii) the qualifications of any person or entity to be covered by the requested insurance to perform professional healthcare services; and (iii) such other information which, in the sole judgment of the company, may have a bearing on whether to issue the requested insurance. I agree to hold harmless any person or entity providing such information to the company and the company, its directors, officers, employees, and agents from any liability arising out of the disclosure of such information, including any liability arising out of errors and omissions in the information disclosed.

**Alabama, Arkansas, Indiana, Kentucky, Minnesota, New Mexico, New York, Rhode Island, Tennessee, Texas, West Virginia Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties which may include voiding of the policy if allowed by state law.

**California Applicants:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Applicants:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulated Agencies.

**District of Columbia Applicants:** 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.

**Florida Applicants:** 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.

**Louisiana Applicants:** 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.

**Maine Applicants:** Per 24-A M.R.S.A. 2186(3), 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 denial of insurance benefits.

**New Jersey Applicants:** Any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Ohio Applicants:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Applicants:** 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.

**Oregon Applicants:** 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 information or conceals for the purpose of

misleading, information concerning any fact material thereto may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. For an insurer to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the insured, the insurer must show that the misinformation is material to the insurance policy, that the insurer relied on the misinformation and that the misinformation was provided fraudulently.

**Pennsylvania Applicants:** 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 information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Virginia Applicants:** 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 denial of insurance benefits.

**Washington Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

_____ Applicant (print name of entity)	_____ Title
_____ Signature of Duty Authorized Officer or Employee	_____ Date
_____ Printed Name of of Duty Authorized Officer or Employee	
_____ Signature of Producer (signature is required for N.H. producers only)	_____ Date
_____ Printed Name of Producer	