SCHOOLS – SUPPLEMENTAL APPLICATION

This is a Supplemental Application which accompanies the Application. The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Supplemental Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Supplemental Application does not bind coverage.

Supplemental Questions

Applicant's Name: ____

1. Indicate facility type:
   - □ Allied Health School (specify)
     - □ ______________________________
   - □ Chiropractic School
   - □ Clinic
   - □ Dental School
   - □ EMT School
   - □ Infirmary
   - □ Medical School
     - □ Research ______________________
     - □ Primary Care ___________________
   - □ Specialty Medical School
     - □ Specialty ______________________
   - □ Nursing School
     - □ Nursing – Registered Nurses
     - □ Nursing – LPN
     - □ Nursing – Nurse's Aide
     - □ Nursing – Other ________________
   - □ Optometry School
   - □ Physical Therapy School
   - □ School of Pharmacy
   - □ Advanced Training to Previously Licensed Professionals ____________________
   - □ Other (specify) ____________________
   - □ Other (specify) ____________________

2. Describe the following information for each program/operation listed above:

For each program/operation indicated in Question #1:	Length of Program	Total Hours (Classroom + Clinical)	Total Clinical Hours Only
1.			
2.			
3.			
4.			
5.			

3. Describe the following information (historical, current, and projected):

Total Number of Faculty and Students	Year _____	Year ______	Current Year ______	Projected Next 12 Months
1. Students Enrolled				
2. Faculty				
3. Nurses				
4. Other (specify):				
5. Other (specify):				
Total # of Individuals				

4. Indicate the revenues for following (historical, current, and projected):

Total $ Revenues	Year _____	Year _____	Current Year _____	Projected Next 12 Months

5. Do faculty members provide direct patient care? □ Yes □ No

6. Do students have direct patient contact? □ Yes □ No
   If yes, describe how patients are supervised? ______________________________________
   ____
   If yes, describe how many patients have been cared for in each of the past 2 years? ____________________
   ____
   If yes, describe specifics of supervision including (1) faculty:student ratios and (2) supervision by others: _____
   ____
   ____

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7. Does your facility require the faculty to carry their own professional liability insurance? □ Yes □ No
   If yes, specify the minimum limits required: ______ Each Person _____ Total Limits
   Do you require written proof of this coverage? □ Yes □ No
8. Are students covered under either:
   (a) Facility's policy? □ Yes □ No
   (b) Faculty's policy? □ Yes □ No
9. Are students participating in any of the following:
   (a) Surgery/Invasive Procedure(s) □ Yes □ No
   (b) Direct Hands-On Patient Care □ Yes □ No
   (c) Observation □ Yes □ No
   (d) Medication Administration □ Yes □ No
   (e) Medical Record Documentation □ Yes □ No
   If yes to any of the above, then describe: ______________________________
   ____
   ____
   If yes to (a), (b) or (c), then how many beds are located in that facility? ______________
10. Where does the clinical portion of training take place?
    (a) School Owned Facility □ Yes □ No
    (b) Non-School Owned Facility □ Yes □ No
    If yes to (b), then describe the Non-School Owned Facility: ______________________________
    ____
    ____
    If the facility is a Non-School Owned, then does a hold harmless agreement take effect? □ Yes □ No
    Explain and provide copy of hold harmless agreement: ______________________________
    ____
    ____
11. Please check the box if the following are submitted:
    □ Marketing Materials
    □ Student Application
    □ Program Overview Materials

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS SUPPLEMENTAL APPLICATION CHANGES BETWEEN THE DATE OF THIS SUPPLEMENTAL APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS SUPPLEMENTAL APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS SUPPLEMENTAL APPLICATION SHALL BE PART OF THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THIS SUPPLEMENTAL APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS SUPPLEMENTAL APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

Name of Applicant: ______________________________

Title: ______________________________

Date: ______________________________