FITNESS PROFESSIONAL APPLICATION

NEW MEMBER APPLICATION FOR COVERAGE AND MEMBERSHIP

Contact and Practice Information:

Full Name (First, Middle, Last)		Practice / Clinic Name		
Office Address (include Suite #)		City	State	Zip
Mailing Address – If Different from Office Address		City	State	Zip
Office Phone	Alternate Phone (Home, Cell, etc.)	Fax	Email	

Practice Information

1. License: Is your fitness license current? ❒Yes ❒No ❒N/A - Certification only. No licensure in my state
2. Certifications: Please include a copy of any Fitness Professional Certifications you hold.
3. Do you hold any healthcare licenses (RN, LMT, DC, etc.)? ❒Yes ❒No If Yes, list:____
4. Do you provide dietary advice to clients? ❒Yes ❒No If Yes, do you limit your advice to general, non-medical advice? ❒Yes ❒No
5. Do you assert to your clients that you treat any condition, disease or injury other than guiding them in managing their general fitness and overall well-being? ❒Yes ❒No If Yes, explain:____

General Background (If you answer Yes to any of the following, attach a detailed explanation including status, dates, and outcomes)

1. Claim History: Has any malpractice claim or allegation ever been asserted against you or your associates ❒Yes ❒No
2. Potential Claims: Are you aware of any event or indication suggesting a claim may be made against you or that your care might have been deficient or caused harm? ❒Yes ❒No
3. License Issues: Has any agency or association ever investigated or taken any action against you or your license? ❒Yes ❒No
4. Insurance: Have you ever had malpractice insurance denied, canceled, or accepted on special terms? ❒Yes ❒No
5. Criminal History: Have you been charged with or convicted of violating any law other than a minor traffic offense? ❒Yes ❒No
6. Compromised Care: Have you ever provided care to patients when your ability to perform your professional duties was compromised because of a condition, or your use of an intoxicant, medication, or other drug? ❒Yes ❒No

Coverage Information

1. Who provides your current malpractice policy? ________________________ Expires: __________
2. Your malpractice coverage, if approved, is effective the date the app is received. For a later date, specify date: __________
3. Do you need Retroactive Coverage ❒Yes ❒No If ***Yes***, indicate your desired retroactive date (charges may apply): __________
4. If you practice using a Professional Corp or Partnership, ***which you own***, list below to add it, free of charge, as an Additional Insured:
____
5. List below to add any other entity added as an Additional Insured (e.g. your Employer, Landlord, etc.). Cost is 5% per entity:
____
____

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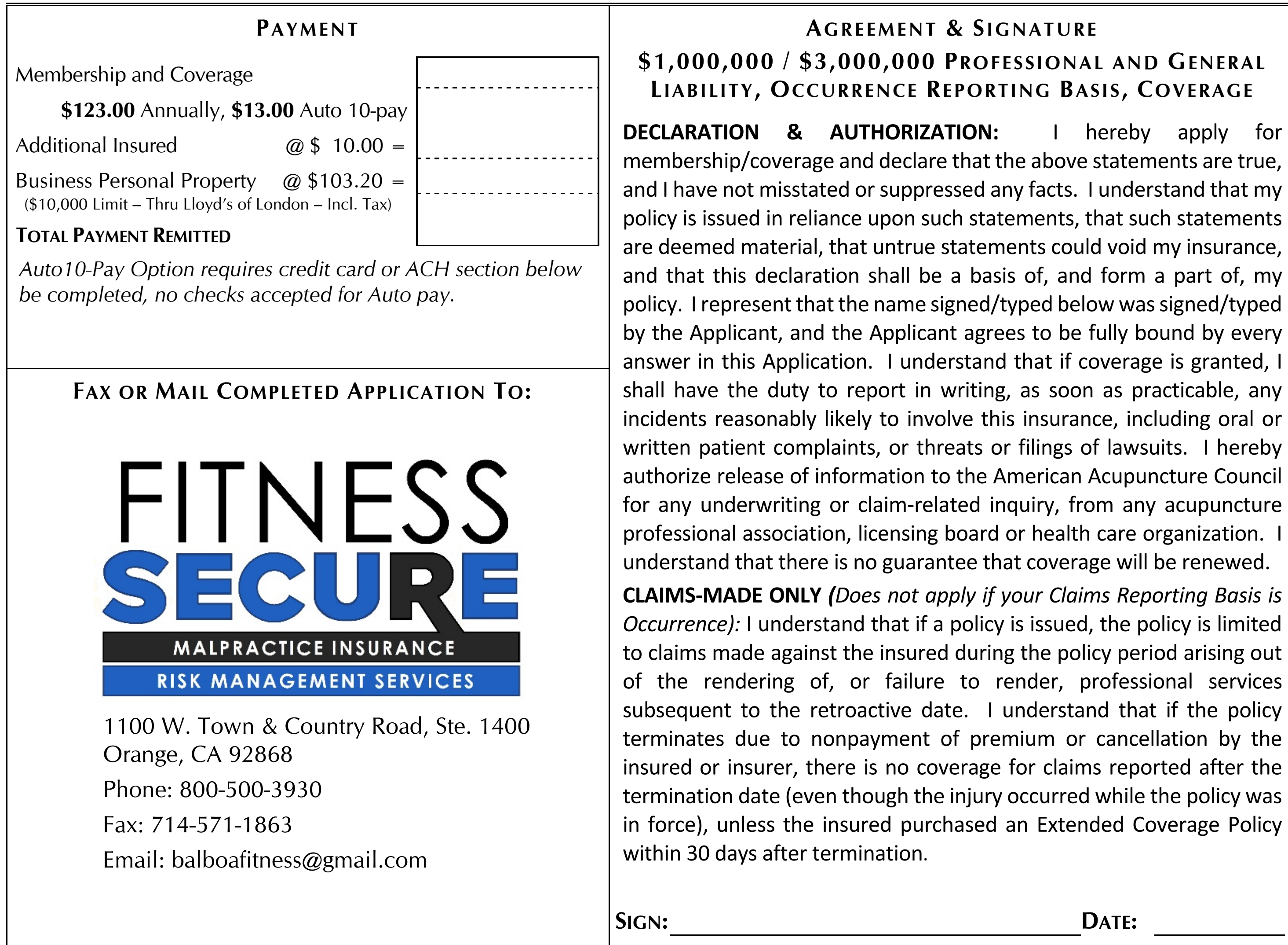
FITNESS PROFESSIONAL APPLICATION

Membership Application



PAYMENT

Membership and Coverage **$123.00** Annually, **$13.00** Auto 10-pay	
Additional Insured @ $ 10.00 =	
Business Personal Property @ $103.20 = ($10,000 Limit – Thru Lloyd's of London – Incl. Tax)	
TOTAL PAYMENT REMITTED	

Auto10-Pay Option requires credit card or ACH section below be completed, no checks accepted for Auto pay.

FAX OR MAIL COMPLETED APPLICATION TO:

FITNESS SECURE
MALPRACTICE INSURANCE
RISK MANAGEMENT SERVICES

1100 W. Town & Country Road, Ste. 1400
Orange, CA 92868

Phone: 800-500-3930

Fax: 714-571-1863

Email: balboafitness@gmail.com

AGREEMENT & SIGNATURE

$1,000,000 / $3,000,000 PROFESSIONAL AND GENERAL LIABILITY, OCCURRENCE REPORTING BASIS, COVERAGE

DECLARATION & AUTHORIZATION: I hereby apply for membership/coverage and declare that the above statements are true, and I have not misstated or suppressed any facts. I understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance, and that this declaration shall be a basis of, and form a part of, my policy. I represent that the name signed/typed below was signed/typed by the Applicant, and the Applicant agrees to be fully bound by every answer in this Application. I understand that if coverage is granted, I shall have the duty to report in writing, as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits. I hereby authorize release of information to the American Acupuncture Council for any underwriting or claim-related inquiry, from any acupuncture professional association, licensing board or health care organization. I understand that there is no guarantee that coverage will be renewed.

CLAIMS-MADE ONLY ***(Does not apply if your Claims Reporting Basis is Occurrence):*** I understand that if a policy is issued, the policy is limited to claims made against the insured during the policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless the insured purchased an Extended Coverage Policy within 30 days after termination.

SIGN: ______________________ **DATE:** __________

Credit Card or ACH (Complete applicable section and sign)

❐ **Credit Card Payments:**

Card Type: ❐Visa ❐MasterCard ❐American Express

Card #: ______________________ Expires: __________

❐ **ACH Payments from Bank Account:**

Account Type: ❐ Checking ❐ Savings

Account #: ______________________ Bank Routing #: ______________________

Bank Name: ______________________ Branch City: ______________________

You are hereby authorized to process payment as indicated above in accordance with applicable issuer agreements. If paying by installments, I authorize that on each due date, the amount due be automatically charged to my Credit Card or debited to my Bank Account, as applicable. I understand that ACH transfers to my account must comply with provisions of U.S. law, and that the authority to initiate debit entries as indicated will remain in effect until I have cancelled it in writing.

Signature: ______________________ **Date:** ______________________