

**WELLNESS PAK PROGRAM APPLICATION  
General and Professional Liability**

**NOTE:** To add Commercial Property, Crime or Inland Marine, attach appropriate ACORD applications or equivalent.

**APPLICANT INFORMATION**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Policy Term \_\_\_\_\_  
 Telephone \_\_\_\_\_ Professional License Type and Number (if required) \_\_\_\_\_

Business Organization:  Individual  Partnership  Corporation  Other \_\_\_\_\_

GL & Prof. Limits Requested: Occurrence \_\_\_\_\_ Personal Injury/Advertising \_\_\_\_\_  
 General Aggregate \_\_\_\_\_ Medical Payments \_\_\_\_\_  
 Prods/Comp Ops Aggregate \_\_\_\_\_ Fire Legal \_\_\_\_\_

Estimated annual payroll \$ \_\_\_\_\_ Estimated annual receipts \$ \_\_\_\_\_ Years in business \_\_\_\_\_

List full names of all individuals or partners and their interests.  
 \_\_\_\_\_  
 \_\_\_\_\_

Applicant is:  In private practice  An employee  Service contractor - List employer  
 or principal under contract \_\_\_\_\_

Check services and procedures provided:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Aide or Assistant         | <input type="checkbox"/> Dietician/Nutritionist | <input type="checkbox"/> Social Work                      |
| <input type="checkbox"/> Audiology                 | <input type="checkbox"/> Guidance Counseling    | <input type="checkbox"/> Therapy (Occupational or Speech) |
| <input type="checkbox"/> Clergy                    | <input type="checkbox"/> Hospice Care           | <input type="checkbox"/> Marriage Counseling              |
| <input type="checkbox"/> Denturist                 | <input type="checkbox"/> Private Counseling     | <input type="checkbox"/> Occupational Counseling          |
| <input type="checkbox"/> Other (Be Specific) _____ |   |   |

Indicate the number of: \_\_\_\_\_ Annual outpatient visits \_\_\_\_\_ Professional employees \_\_\_\_\_ Participants

Describe all professional training, licensing or certification requirements achieved, memberships in professional organizations \_\_\_\_\_  
 \_\_\_\_\_

List additional insureds \_\_\_\_\_

**THREE YEAR LOSS EXPERIENCE**

Date

Losses (description and amounts paid and incurred)

_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
 Applicant Signature & Date

\_\_\_\_\_  
 Producer Name & Address

**NOTICE OF INSURANCE INFORMATION PRACTICES**

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED

TO THIRD PARTIES. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTION ON HOW TO SUBMIT A REQUEST TO US.

**COVERAGE NOT BOUND UNTIL APPROVED BY THE COMPANY.**