

SERFF Tracking Number: DRWN-125742378 State: Arkansas
 Filing Company: Darwin National Assurance Company State Tracking Number: EFT \$50
 Company Tracking Number: 2008-7009-AK-RFL
 TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0018 Premises & Operations (OL&T and M&C)
 Product Name: Allied Healthcare Application Refile
 Project Name/Number: Allied Healthcare Application Refile/2008-7009-AK-RFL

Filing at a Glance

Company: Darwin National Assurance Company

Product Name: Allied Healthcare Application Refile SERFF Tr Num: DRWN-125742378 State: Arkansas

Refile

TOI: 17.0 Other Liability - Claims Made/Occurrence SERFF Status: Closed State Tr Num: EFT \$50

Sub-TOI: 17.0018 Premises & Operations (OL&T and M&C) Co Tr Num: 2008-7009-AK-RFL State Status: Fees verified and received

Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Edith Roberts, Brittany Yielding

Authors: Elizabeth Stefanow, Amy La Panne Disposition Date: 08/12/2008

La Panne

Date Submitted: 07/22/2008 Disposition Status: Approved

Effective Date Requested (New): On Approval

Effective Date (New):

Effective Date Requested (Renewal): On Approval

Effective Date (Renewal):

State Filing Description:

General Information

Project Name: Allied Healthcare Application Refile

Status of Filing in Domicile: Pending

Project Number: 2008-7009-AK-RFL

Domicile Status Comments:

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 08/12/2008

State Status Changed: 08/12/2008

Deemer Date:

Corresponding Filing Tracking Number: 2008-7009-AK-R

Filing Description:

Darwin is refiling the form, Physical Therapists and Related Occupations Application, DRWN c1010-PT (6/2008). The changes have been made in order to provide a single application for countrywide use. We have included two copies of the application for your review: one copy with red font indicating the additions made to the application, and one copy of the form in its final state. We have only added text to the application; no text has been removed or altered, with the

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exception of the edition date of the form.

This form was originally filed with the Department on 07/09/2008 under SERFF tracking number DRWN-125726593

We propose to begin using this program immediately upon your earliest review and approval.

Company and Contact

Filing Contact Information

Elizabeth Stefanow, Compliance Analyst estefanow@darwinpro.com
 9 Farm Springs Road (860) 284-1978 [Phone]
 Farmington, CT 06032 (860) 284-1979[FAX]

Filing Company Information

Darwin National Assurance Company CoCode: 16624 State of Domicile: Delaware
 9 Farm Springs Road Group Code: 501 Company Type:
 Farmington, CT 06032 Group Name: Alleghany Insurance State ID Number:
 Group
 (860) 284-1300 ext. [Phone] FEIN Number: 56-0997452

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Submission is revising form with more than just basic changes.
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Darwin National Assurance Company	\$50.00	07/22/2008	21529497

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	08/12/2008	08/12/2008

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Disposition

Disposition Date: 08/12/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Allied Healthcare Application	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Allied Healthcare Application	DRWN c1010-PT	6/2008	Application/ Replaced Binder/Enrollment	Replaced Form #: DRWN c1010-PT (7/2008) Previous Filing #: DRWN c1010-PT (6/2008)		7-08 - Allied Heath Care Application Individual PT.pdf All Risk Application _REDLINE_.pdf

Physical Therapists and Related Occupations Application

- | | | |
|--|---|--|
| <input type="checkbox"/> <u>Darwin National Assurance Company</u> | <u>Main Administrative Office:</u>
9 Farm Springs Road
Farmington, CT 06070 | <u>Corporate Office:</u>
1807 North Market Street
Wilmington, DE 19802 |
| <input type="checkbox"/> <u>Darwin Select Insurance Company</u> | | |

Offered through the Professional Counselors Purchasing Group, Inc.

NOTICE: THIS IS AN APPLICATION FOR PROFESSIONAL AND PREMISES LIABILITY INSURANCE. SUBJECT TO ITS TERMS, THIS POLICY PROVIDES COVERAGE FOR CLAIMS ARISING FROM WRONGFUL ACTS OR OCCURRENCES THAT TAKE PLACE DURING THE POLICY PERIOD.

DEFENSE EXPENSES PAYABLE UNDER THE POLICY MAY BE PAYABLE IN ADDITION TO THE LIMITS OF LIABILITY, OR MAY REDUCE AND MAY EXHAUST THE APPLICABLE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS, DEPENDING ON THE COVERAGE WHICH IS APPLICABLE. A SMALLER LIMIT OF LIABILITY WILL APPLY TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT, OR TO ANY SUPPLEMENTAL PAYMENT.

If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

- Attach a separate sheet of paper if more space is needed to answer any question.
- Attach copy of current state license or certification
- Attach promotional materials used in your practice
- Attach any claims history for professional or premises liability

Are You:

- Self-Employed** (Self-Employed means an individual working for themselves or with others as partners or as owners of a group or entity.)
- Employee** (Employee means a person who has been hired to perform services, and who has an assigned work schedule and appears on a payroll with applicable federal, state and local taxes withheld, e.g. W-2.)
- Student**

(1) General Information

- (a) Applicant's Name: _____
- (b) Address: _____
City: _____ State: _____ ZIP: _____
- (c) E-mail address: _____ Telephone number _____
- (d) License/Certification # (if applicable) _____
- (e) If You answered **Self-Employed**, please provide the following additional information:

(i) Are You a:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> PC | <input type="checkbox"/> Sole Proprietor/Individual | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> LLP | <input type="checkbox"/> LLC | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Other | |

If Other, please describe: _____

Name of Entity if different than Name of Applicant: _____

Key Contact Name: _____ Title: _____

(ii) Are You seeking Premises Liability coverage?
 Yes No

(iii) Are You required by contract to include an individual or entity as an additional insured under the policy for professional services you or any of your employees provide?

(Additional Insured coverage protects a third party You provide services for against claims arising out of wrongful acts. You should only purchase this coverage if you are required to.)
 Yes No

(iv) Are You seeking coverage for any subsidiary? Please note that coverage for such subsidiaries is not automatically available; the terms and conditions of the policy, if issued, will determined actual coverage.
 Yes No

Name/Address	Relation to applicants	Description of Ops	Tax Status	Percent Owned

(f) If You answered **Employee**, please provide the following additional information:

Employer Name: _____

Employer City, State: _____

(2) Requested Effective Date: _____

(3) Description of Practice

(a) Eligible Occupations - Please check all Specialties performed in Your practice:

- a. Athletic Trainer
- b. Bodywork Counselor
- c. Chiropractic Assistant
- d. Corrective Therapist
- e. Exercise Physiologist
- f. Fitness Instructor
- g. Kinesiologist
- h. Kinesiotherapist
- i. Massage Therapist
- j. Occupational Therapist
- k. Occupational Therapist Assistant
- l. Orthopedic Assistant
- m. Orthopedic Technician
- n. Pedorthist
- o. Personal Trainer
- p. Physical Therapist
- q. Physical Therapist Aide
- r. Physical Therapist Assistant
- s. Physiotherapist
- t. Recreational Therapist
- u. Rehabilitation Assistant
- v. Rehabilitation Counselor
- w. Rehabilitation Technician
- x. Rehabilitation Therapist
- y. Sports Medicine Instructor
- z. Sports Medicine Therapist

- (c) Have You or any of your employees or independent contractors ever engaged in any sexual misconduct with any of Your current or former patients, or any current or former patient's spouse, or any person with a direct relationship to a current or former patient or any current or former patient's spouse or any person with a direct relationship to the patient or former patient (for example, a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?

(Sexual misconduct means any actual or alleged erotic physical contact or attempt, threat or proposal thereof whether consensual or not.)

Yes No

If You answered "Yes" to the questions (6)(a), (6)(b) or (6)(c) above, provide complete details on a separate page and attach it to the application.

MISSOURI APPLICANTS DO NOT ANSWER QUESTION (7).

- (7) During the past five years, has Your Professional Liability coverage been cancelled or non-renewed for a reason other than the insurer withdrawing from a state or no longer providing coverage?

Yes No

If You answered "Yes" to the question above, provide complete details on a separate page and attach it to the application.

SIGNATURES, NOTICES AND REPRESENTATIONS

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, PARTNER, DIRECTOR OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY THE INSURER IN WRITING OF SUCH CHANGES. THE INSURER RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS OR ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF AND AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ARE TRUE AND ACCURATE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE INSURER, ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE INSURER.

NOTICE TO APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, 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 ACT, WHICH IS A CRIME ANY MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND WEST VIRGINIA 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.

NOTICE TO 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMING WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO 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.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA AND NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MAINE, TENNESSEE, VIRGINIA, AND 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.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO 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.

NOTICE TO 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.

NOTICE TO 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.

I UNDERSTAND THAT IT IS MY OBLIGATION TO MAINTAIN ANY LICENSE REQUIRED IN THE JURISDICTION(S) IN WHICH I PRACTICE.

Date: _____

Signature: _____

Title: _____

Print Name: _____

Signature of Authorized Representative of the American Professional Agency, Inc.:

Please make checks payable and mail to: American Professional Agency, Inc.

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

www.americanprofessional.com

Physical Therapists and Related Occupations Application

- | | | |
|--|---|--|
| <input type="checkbox"/> <u>Darwin National Assurance Company</u> | <u>Main Administrative Office:</u>
9 Farm Springs Road
Farmington, CT 06070 | <u>Corporate Office:</u>
1807 North Market Street
Wilmington, DE 19802 |
| <input type="checkbox"/> <u>Darwin Select Insurance Company</u> | | |

Offered through the Professional Counselors Purchasing Group, Inc.

NOTICE: THIS IS AN APPLICATION FOR PROFESSIONAL AND PREMISES LIABILITY INSURANCE. SUBJECT TO ITS TERMS, THIS POLICY PROVIDES COVERAGE FOR CLAIMS ARISING FROM WRONGFUL ACTS OR OCCURRENCES THAT TAKE PLACE DURING THE POLICY PERIOD.

DEFENSE EXPENSES PAYABLE UNDER THE POLICY MAY BE PAYABLE IN ADDITION TO THE LIMITS OF LIABILITY, OR MAY REDUCE AND MAY EXHAUST THE APPLICABLE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS, DEPENDING ON THE COVERAGE WHICH IS APPLICABLE. A SMALLER LIMIT OF LIABILITY WILL APPLY TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT, OR TO ANY SUPPLEMENTAL PAYMENT.

If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

- Attach a separate sheet of paper if more space is needed to answer any question.
- Attach copy of current state license or certification
- Attach promotional materials used in your practice
- Attach any claims history for professional or premises liability

Are You:

- Self-Employed** (Self-Employed means an individual working for themselves or with others as partners or as owners of a group or entity.)
- Employee** (Employee means a person who has been hired to perform services, and who has an assigned work schedule and appears on a payroll with applicable federal, state and local taxes withheld, e.g. W-2.)
- Student**

(1) General Information

- (a) Applicant's Name: _____
- (b) Address: _____
City: _____ State: _____ ZIP: _____
- (c) E-mail address: _____ Telephone number _____
- (d) License/Certification # (if applicable) _____
- (e) If You answered **Self-Employed**, please provide the following additional information:

(i) Are You a:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> PC | <input type="checkbox"/> Sole Proprietor/Individual | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> LLP | <input type="checkbox"/> LLC | <input type="checkbox"/> Corporation |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Other | |

If Other, please describe: _____

Name of Entity if different than Name of Applicant:

Key Contact Name: _____ Title: _____

(ii) Are You seeking Premises Liability coverage?
 Yes No

(iii) Are You required by contract to include an individual or entity as an additional insured under the policy for professional services you or any of your employees provide?

(Additional Insured coverage protects a third party You provide services for against claims arising out of wrongful acts. You should only purchase this coverage if you are required to.)
 Yes No

(iv) Are You seeking coverage for any subsidiary? Please note that coverage for such subsidiaries is not automatically available; the terms and conditions of the policy, if issued, will determined actual coverage.
 Yes No

Name/Address	Relation to applicants	Description of Ops	Tax Status	Percent Owned

(f) If You answered **Employee**, please provide the following additional information:

Employer Name: _____

Employer City, State: _____

(2) Requested Effective Date: _____

(3) Description of Practice

(a) Eligible Occupations - Please check all Specialties performed in Your practice:

- a. Athletic Trainer
- b. Bodywork Counselor
- c. Chiropractic Assistant
- d. Corrective Therapist
- e. Exercise Physiologist
- f. Fitness Instructor
- g. Kinesiologist
- h. Kinesiotherapist
- i. Massage Therapist
- j. Occupational Therapist
- k. Occupational Therapist Assistant
- l. Orthopedic Assistant
- m. Orthopedic Technician
- n. Pedorthist
- o. Personal Trainer
- p. Physical Therapist
- q. Physical Therapist Aide
- r. Physical Therapist Assistant
- s. Physiotherapist
- t. Recreational Therapist
- u. Rehabilitation Assistant
- v. Rehabilitation Counselor
- w. Rehabilitation Technician
- x. Rehabilitation Therapist
- y. Sports Medicine Instructor
- z. Sports Medicine Therapist

- (b) List Your name and qualifications. In addition, list the names and qualifications of each individual who performs services for You or on Your behalf, except clerical services. If additional space is required, please use a separate sheet of paper.

Name	Degree		Specialty/ Specialties (List all specialties performed)	Number of hours of practice each week	License or Certification				Employment Status (Indicate Partner or Owner, Employee (W-2), Independent Contractor (Form 1099), or Student.)
	Degree Title	Field Of Study			State	Title	Number	Expiration Date	

NOTE: Independent Contractors (Form 1099) are not covered under this Policy, unless specifically included by Endorsement. You will, however, be covered for their acts, subject to the terms and conditions of the Policy. If You have listed Independent Contractors above, more information may be requested from the Insurer, as well as additional premium, to include them in the coverage available under the Policy.

- (4) Do You and Your employees, or independent contractors, have a degree, certification or training from an accredited institution, association, licensing board, or regulatory agency responsible for maintaining the standards of the specialty/specialties selected?
 Yes No
- (5) Do You or any of Your employees or independent contractors practice any of the specialties selected at any jail, prison, correctional facility or any similar type of facility?
 Yes No
- (6) Suits, Claims or Potential Claims
- (a) Has any claim or lawsuit for malpractice ever been brought against You or any of Your employees or independent contractors?
 Yes No
- (b) Have You or any of Your employees or independent contractors ever been the subject of complaints, charges, or disciplinary action against You for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of Your profession?
 Yes No

- (c) Have You or any of your employees or independent contractors ever engaged in any sexual misconduct with any of Your current or former patients, or any current or former patient's spouse, or any person with a direct relationship to a current or former patient or any current or former patient's spouse or any person with a direct relationship to the patient or former patient (for example, a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?

(Sexual misconduct means any actual or alleged erotic physical contact or attempt, threat or proposal thereof whether consensual or not.)

Yes No

If You answered "Yes" to the questions (6)(a), (6)(b) or (6)(c) above, provide complete details on a separate page and attach it to the application.

MISSOURI APPLICANTS DO NOT ANSWER QUESTION (7).

- (7) During the past five years, has Your Professional Liability coverage been cancelled or non-renewed for a reason other than the insurer withdrawing from a state or no longer providing coverage?

Yes No

If You answered "Yes" to the question above, provide complete details on a separate page and attach it to the application.

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THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, PARTNER, DIRECTOR OR OFFICER AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE THE APPLICATION IS EXECUTED AND THE TIME THE PROPOSED INSURANCE POLICY IS BOUND OR COVERAGE COMMENCES, THE NAMED INSURED WILL IMMEDIATELY NOTIFY THE INSURER IN WRITING OF SUCH CHANGES. THE INSURER RESERVES ITS RIGHTS TO MODIFY OR WITHDRAW ITS PROPOSAL.

THE UNDERSIGNED AUTHORIZED REPRESENTATIVE, REPRESENTS AND WARRANTS ON BEHALF OF THE NAMED INSURED AND ALL PERSONS OR ENTITIES FOR WHOM INSURANCE IS BEING SOUGHT THAT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF AND AFTER DILIGENT INQUIRY, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ARE TRUE AND ACCURATE. IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE INSURER, ARE MATERIAL TO THE ACCEPTANCE OF THE RISK, AND RELIED UPON BY THE INSURER.

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NOTICE TO 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMING WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO 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.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA AND NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MAINE, TENNESSEE, VIRGINIA, AND 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.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK 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 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO 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.

NOTICE TO 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.

NOTICE TO 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.

I UNDERSTAND THAT IT IS MY OBLIGATION TO MAINTAIN ANY LICENSE REQUIRED IN THE JURISDICTION(S) IN WHICH I PRACTICE.

Date: _____

Signature: _____

Title: _____

Print Name: _____

Signature of Authorized Representative of the American Professional Agency, Inc.:

Please make checks payable and mail to: American Professional Agency, Inc.

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

www.americanprofessional.com

SERFF Tracking Number: DRWN-125742378 *State:* Arkansas
Filing Company: Darwin National Assurance Company *State Tracking Number:* EFT \$50
Company Tracking Number: 2008-7009-AK-RFL
TOI: 17.0 Other Liability - Claims Made/Occurrence *Sub-TOI:* 17.0018 Premises & Operations (OL&T and M&C)

Product Name: Allied Healthcare Application Refile
Project Name/Number: Allied Healthcare Application Refile/2008-7009-AK-RFL

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: DRWN-125742378 State: Arkansas
Filing Company: Darwin National Assurance Company State Tracking Number: EFT \$50
Company Tracking Number: 2008-7009-AK-RFL
TOI: 17.0 Other Liability - Claims Made/Occurrence Sub-TOI: 17.0018 Premises & Operations (OL&T and M&C)
Product Name: Allied Healthcare Application Refile
Project Name/Number: Allied Healthcare Application Refile/2008-7009-AK-RFL

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-
Property & Casualty

Review Status: Approved 08/12/2008

Comments:

Attachment:

transmittal documents.pdf

Property & Casualty Transmittal Document

Reset Form

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

3.	Group Name	Group NAIC #			
	Alleghany Corporation	0501			
4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	Darwin National Assurance Company	DE	16624	56-0997452	

5.	Company Tracking Number	2008-7009-AK-RFL
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Elizabeth Stefanow, 9 Farm Springs Road, Farmington, CT 06032	Compliance Analyst	(860)-284-1978	(860)-284-1979	estefanow@darwinpro.com
7.	Signature of authorized filer				
8.	Please print name of authorized filer  Elizabeth Stefanow				

Filing information (see General Instructions for descriptions of these fields)

9.	Type of Insurance (TOI)	17.2 Other Liability-Occ Only
10.	Sub-Type of Insurance (Sub-TOI)	17.2019 Professional Errors and Omissions Liability
11.	State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12.	Company Program Title (Marketing title)	Allied Healthcare Application Refile
13.	Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14.	Effective Date(s) Requested	New: Upon Approval Renewal: Upon Approval
15.	Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16.	Reference Organization (if applicable)	N/A
17.	Reference Organization # & Title	N/A
18.	Company's Date of Filing	N/A
19.	Status of filing in domicile	<input type="checkbox"/> Not Filed <input checked="" type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking # 2008-7009-AK-RFL

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Darwin is refiling the form, Physical Therapists and Related Occupations Application, DRWN c1010-PT (6/2008). The changes have been made in order to provide a single application for countrywide use. We have included two copies of the application for your review: one copy with red font indicating the additions made to the application, and one copy of the form in its final state. We have only added text to the application; no text has been removed or altered, with the exception of the edition date of the form.

This form was originally filed with the Department on 07/09/2008 under SERFF tracking number DRWN-125726593.

We propose to begin using this program immediately upon your earliest review and approval.

[View Complete Filing Description](#)

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT

Amount: \$50.00

Change made to originally filed application.

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

***Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)

FORM FILING SCHEDULE

(This form must be provided **ONLY** when making a filing that includes forms)
 (Do **not** refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	2008-7009-AK-RFL			
2.	This filing corresponds to rate/rule filing number <small>(Company tracking number of rate/rule filing, if applicable)</small>	2008-7009-AK-R			
3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	DRWN c1010-PT	(7/2008)	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	DRWN c1010-PT (6/2008)	DRWN-125726593
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1