HEALTH & LIFE COACH

Professional Liability Coverage Application

Contact Information

Full Name (First, Middle, Last) | Practice / Clinic Name

Primary Practice Address (Include Suite #) | City | State | Zip

Mailing Address – If Different from Practice Address | City | State | Zip

Email | Cell Phone | Office Phone | Fax

Practice Background

1. Provide the following details regarding your Health / Life Coach training and certification, along with any other current professional designation(s) you hold. Include license number and expiration when applicable:

Name of Health & Life Training Program | Certification Number | Training Hours

Other Designation /License # | Expires | Other Designation / License # | Expires | Other Designation / License # | Expires

2. Do you limit your practice to only providing guidance and inspiration to individuals who desire to maintain or improve behavior, increase their activity, and develop healthy eating practices and lifestyle behaviors? ❒Yes ❒No

   (***If No,*** please explain) _____

3. As a part of your practice, do you provide any other services, such as Colonic Irrigations, Weight Management, etc.; or treat or diagnose any condition, disease or injury, including, but not limited to Emotional and Mental Health, Cancer/Epilepsy, practicing Obstetrics, or making a Differential Diagnosis? ❒Yes ❒No

   (***If Yes,*** please explain) _____

Claims and Other History

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

4. Has any malpractice claim or allegation ever been asserted against you or your associates? ❒Yes ❒No
5. Are you aware of any event or indication suggesting a claim may be made against you or that your Health and Life services might have been deficient or caused harm? ❒Yes ❒No
6. Has any agency or association ever investigated or taken any action against you or your license? ❒Yes ❒No
7. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? ❒Yes ❒No
8. Have you been charged with or convicted of violating any law other than a minor traffic offense? ❒Yes ❒No
9. Have you ever provided services to clients 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

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Coverage and Payment Options - $1,000,000 / $3,000,000 Limits

10. Effective Date: If approved, the date your app is received, unless you indicate a later date here: _____

11. Additional Insured: You may add an additional insured for $10 / entity. To add an Additional Insured, list below:

_____

12. Business Personal Property (BPP) Coverage: You may add $10,000 of BPP coverage for your practice location for $110.00. To apply to a different address, provide here: _____

13. Who provides your current malpractice policy? _____ Expires: _____

Amount Due (Select Options)

Professional & Premises Liability Coverage and Options

☑ $1,000,000 / $3,000,000:	**$169.00**
☐ Additional Insureds ($10 each):	
☐ Optional Property Coverage: Limits of $10,000, Cost is $110.00 (Issued by Lloyd's of London)	
Total Amount Due:	

Payment Method (Complete applicable section.)

Credit Card Type: ☐Visa ☐MasterCard ☐American Express

Name on Card: _____

Card #: _____ Exp: _____

ACH Payments from: ☐ Personal Account ☐ Business Account

Account Name: _____

Account #: _____

Bank Name: _____

Bank Routing #: _____

Bank City: _____

Declaration, Acknowledgement, Authorization & Signature

Declaration: I, the applicant, represent that: 1) I am applying for membership/coverage; 2) I signed/typed my name in the place(s) provided herein; and 3) The above statements are true, and I have not misstated or suppressed any facts**.** I understand that: 1) If coverage is granted, my policy is issued in reliance upon such statements; 2) Such statements are deemed material; 3) Untrue statements could void my insurance; 4) This declaration, along with the information and disclosures contained herein, including any supplemental clarifications, are all a part of my application, shall be the basis of, and form a part of, my Policy, and shall apply to any subsequent renewal of that Policy; 5) There is no guarantee that coverage will be renewed; and 6) The Policy requires that I report, in writing, within 3 days, or as soon as practicable, incidents reasonably likely to involve this insurance, including oral or written patient complaints, threats, or lawsuits.

Claims Made: I understand that my Policy will be limited to claims made against me during the Policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that the Claims Made option provides that if the Policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the Policy was in force), unless I purchase Extended Coverage within 30 days after termination.

Authorization: If coverage is granted, I authorize you to: 1) Process payments or refunds when due, including any installments, by charging the Credit Card or debiting the Bank Account provided, in accordance with the terms of any Payment Authorization form relating to this application and in compliance with issuer agreements and U.S. law, and agree that this authority will remain in effect until I have canceled it in writing; 2) Request and receive information about me for any underwriting or claim-related inquiry from any professional association, licensing board or health care organization; and 3) Opt me in and allow the Company to communicate with me through Email, Fax, Phone, and SMS/ MMS messaging or other text messaging platforms.

Sign here: _____ **Date:** _____

Submit Application: **By Email**: Info@councilsupport.com **By Fax**: 714-571-1863