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

Facilities/Schools	Length of Program	Total Hours (Classroom + Clinical)	Total Clinical Hours Only
Other			

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

Enrollment, Staff and Revenue			Current Year	Projected Next 12 Months
1. Students Enrolled				
2. Faculty				
3. Nurses				
4. Other (specify):				
Total # of Individuals				
Revenue				

3. Do faculty members provide direct patient care?
4. Do students have direct patient contact?
   If yes, describe how patients are supervised:

   If yes, how many patients have been cared for in each of the past 2 years?

   Describe specifics of supervision:
   (1) faculty:student ratios (2) supervision by others:

5. If the applicant's facility requires the faculty to carry their own professional liability insurance specify the minimum limits required or enter N/A:

   Does the applicant require written proof of this coverage?
6. Are students covered under either:
   (a) Facility's policy?
   (b) Faculty's policy?

SCHOOLS – SUPPLEMENTAL APPLICATION

7. Are students participating in any of the following:
   - (a) Surgery/Invasive Procedure(s)
   - (b) Direct Hands-On Patient Care
   - (c) Observation
   - (d) Medication Administration
   - (e) Medical Record Documentation

   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?

8. Where does the clinical portion of training take place?
   - (a) School Owned Facility
   - (b) Non-School Owned Facility

   Describe non-school owned facility training, if any:

9. 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:

Please submit the following:

- Marketing Materials
- Student Application
- Program Overview Materials
- Loss History – Submit company produced 5 year loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses)

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.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

Name of Applicant: ______________________________

Title: ______________________________

Signature: ______________________________

Date: ______________________________