

ORTHOPAEDIC TECHNOLOGISTS INSURANCE PURCHASING GROUP
APPLICATION FOR ORTHOPAEDIC TECHNOLOGISTS
PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

1. APPLICANT INFORMATION

- a. Full name of applicant: _____
- b. Mailing address: _____
(Street)

(City) (State) (Zip) (County)
- Phone No.: _____ Email Address: _____
- c. Date of Birth: _____ Social Security No.: _____
- d. Are you practicing as an: Orthopaedic Technologist _____ Orthopaedic Technologist - Surgery _____
- e. Number of years experience as an: Orthopaedic Technologist _____ Orthopaedic Technologist - Surgery _____
- f. Educational Institutions that you have attended for Orthopaedic Technologist (or related) Training:
- | <u>Name and City, State</u> | <u>Years of Training</u> | <u>Degree or Certification Attained</u> |
|-----------------------------|--------------------------|---|
| _____ | From _____ To _____ | _____ |
| _____ | From _____ To _____ | _____ |
- g. Estimated annual caseload number in which you are involved: Adult _____ Pediatric _____
- h. Your duties are performed under the supervision of (e.g. physician, surgeon, physician assistant, other - describe): _____

- i. Please list all states and any foreign countries where you provide service: _____

- j. Please give the approximate percentage of total service time spent in the following locations:
- | | | |
|--------------------------------|---|----------------------------------|
| _____ % Outpatient Clinic | _____ % Operating Room | _____ % Hospital Ward (specify): |
| _____ % Surgery Center | _____ % Emergency Dept. of Hospital | _____ |
| _____ % Other (specify): _____ | _____ % Physician Office (specify specialty): | _____ |
- k. Please indicate the approximate division of your patients or clients among:
- | | | |
|--------------------------------|---------------------------------|--------------------------|
| _____ % Surgical | _____ % Physical Rehabilitation | _____ % Other (specify): |
| _____ % Other (specify): _____ | _____ | _____ |

2. CLAIMS/HISTORY

If "Yes" to any of the questions below, attach a detailed explanation.

- a. Have you been reprimanded or the subject of investigatory or disciplinary actions or proceedings of any kind? Yes No
- b. Has any insurance company ever canceled, non-renewed or declined to accept your professional liability insurance? Yes No
- c. Have you been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No

- d. Have you been treated for alcoholism or drug addiction or undergone personal psychiatric treatment? Yes No
- e. Has any professional liability claim or suit been brought against you? Yes No
 If Yes, please provide all dates and details of any incidents or payments: _____
-
- f. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you? Yes No
 If Yes, attach an explanation.
- g. List prior professional liability insurance carried for each of the past five years. IF NONE, STATE NONE.

<u>Insurance Company</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Mo./Day/Yr.</u>	<u>Was this a Claims Made Policy Form?</u>		<u>Retro Date</u>
						<u>Yes</u>	<u>No</u>	
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: ATTACH YOUR NBCOT PROOF OF CURRENT CERTIFICATION

*NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the insurance coverage and deemed incorporated therein, should the Insurer evidence its acceptance of this application by binding insurance.

 Name of Applicant

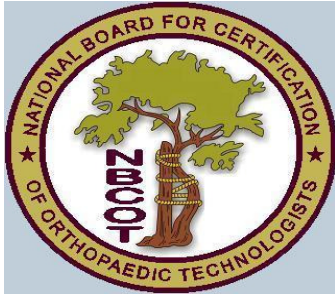
 Signature of Applicant

 Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if insurance is bound.

This insurance contract is with an insurer not licensed to transact insurance in this state and is issued and delivered as a surplus line coverage under the Texas insurance statutes. The Texas Department of Insurance does not audit the finances or review the solvency of the surplus lines insurer providing this coverage, and the insurer is not a member of the property and casualty insurance guaranty association created under Chapter 462, Insurance Code. Chapter 225, Insurance Code, requires payment of a 4.85 percent tax on gross premium.

Orthopaedic Technologist Insurance Purchaser Group
 2600 Ridge Rd., Ste. 104
 Rockwall, TX 75087
 972-771-8301
 Toll Free 800-759-1485
 Fax 972-771-8889



ORTHOPAEDIC TECHNOLOGISTS INSURANCE PURCHASING GROUP
APPLICATION FOR ORTHOPAEDIC TECHNOLOGISTS
PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

Payment Terms (if application is accepted):

For \$1,000,000 each claim / \$3,000,000 aggregate limits for OTC

\$1,000.00 If bound Sept. 1 st through Feb. 28 th of Policy Year \$ 50.00 Policy Fee \$ 50.93 TX Surplus Lines Tax \$ <u>.63</u> \$1,101.56 Total	\$500.00* If bound March 1 st through August 31 st of Policy Year \$ 25.00 Policy Fee \$ 25.46 TX Surplus Lines Tax Stamping Fee \$ <u>.32</u> Stamping Fee \$550.78 Total
--	---

*50% reduction in premium when purchasing insurance during the last half of a policy year.

For \$500,000 each claim / \$1,500,000 aggregate limits for OTC

\$750.00 If bound Sept. 1 st through Feb. 28 th of Policy Year \$ 50.00 Policy Fee \$ 38.80 TX Surplus Lines Tax \$ <u>.48</u> Stamping Fee \$839.28 Total	\$375.00* If bound March 1 st through August 31 st of Policy Year \$ 25.00 Policy Fee \$ 19.40 TX Surplus Lines Tax \$ <u>.24</u> Stamping Fee \$419.64 Total
---	--

*50% reduction in premium when purchasing insurance during the last half of a policy year.

For \$1,000,000 each claim / \$3,000,000 aggregate limits for OT-SC

\$1,500.00 If bound Sept. 1 st through Feb. 28 th of Policy Year \$ 50.00 Policy Fee \$ 75.18 TX Surplus Lines Tax \$ <u>.93</u> Stamping Fee \$1,626.11 Total	\$750.00* If bound March 1 st through August 31 st of Policy Year \$ 25.00 Policy Fee \$ 37.59 TX Surplus Lines Tax \$ <u>.47</u> Stamping Fee \$813.06 Total
---	--

*50% reduction in premium when purchasing insurance during the last half of a policy year.

For \$500,000 each claim / \$1,500,000 aggregate limits for OT-SC

\$1,250.00 If bound Sept. 1 st through Feb. 28 th of Policy Year \$ 50.00 Policy Fee \$ 63.05 TX Surplus Lines Tax \$ <u>.78</u> Stamping Fee \$1,363.83 Total	\$625.00* If bound March 1 st through August 31 st of Policy Year \$ 25.00 Policy Fee \$ 31.53 TX Surplus Lines Tax \$ <u>.39</u> Stamping Fee \$681.92 Total
---	--

*50% reduction in premium when purchasing insurance during the last half of a policy year.

Attach check made payable to Dyer Insurance Agency for the Total or Submit credit card information: MC Visa

Account No.: _____ - _____ - _____ - _____ Expiration Mo./Yr.: _____ / _____

Billing Name: _____ Full Billing Address: _____

I authorize charge of \$ _____ to my credit card. _____, Date _____
 (signature)