employed 1008
Administered by Forrest T. Jones & Company*
3130 Broadway ◆ P.O. Box 418131 ◆ Kansas City, MO 64141-8131
*For AZ residents, administrator is Forrest T. Jones Consulting Company

ACSM
Professional and General Liability Plan

Instructions

How do I apply?

1. Complete the application online. *(If you prefer to complete the application by hand, please type or print all answers in ink.)*

2. **Print** the completed form -- **sign** *(we suggest you keep one copy of the signed application with your important papers)* and **mail** it to:

Forrest T. Jones and Company, Inc.
P O Box 418131
Kansas City, MO 64141-8131

OR fax the signed application to:

Forrest T. Jones and Company, Inc.
(816) 968-0600
Attn: P&C Department

Is my satisfaction guaranteed?

Yes. When you receive your certificate of insurance, review it carefully. If you are not completely satisfied with the terms of your coverage, simply return your certificate within 30 days, and any premiums that have been paid will be promptly refunded in full (less any claims paid).

What if I have questions?

Contact us by e-mail, postal mail, or telephone and we will be happy to answer your questions.

info@ftj.com

Forrest T. Jones and Company, Inc.
P O Box 418131
Kansas City, MO 64141-8131

866.820.5183

Thank you for your interest in this valuable coverage.

Not available in all states.

Application begins on next page ➔

Employed/Self-Employed

Professional and General Liability Insurance Application for The American College of Sports Medicine (ACSM)

4S

NOTE: THIS APPLICATION IS FOR A CLAIMS-MADE INSURANCE POLICY

Plan Administered by Forrest T. Jones & Company Via Hays Affinity Solutions.
Program Underwritten by Lloyd's of London®

Questions?

Forrest T. Jones & Company
toll free 866-820-5183
fax 816-968-0600
www.ftj.com/acsm

Hays Affinity Solutions
LLOYD'S

Section I: Applicant Information

Company Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Business Telephone: _____ E-Mail Address: _____

Home Telephone: _____ Mobile Telephone: _____

☐ Membership Number: _____
☐ Certified Professional _____

You must be an ACSM member or certified professional to apply for this coverage.

Section II: Education and Certifications

Education (Highest Degree Earned)

☐ High School Diploma
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Ph.D.

Certification

Health Fitness
☐ CPT ☐ Health/fitness Instructor
Clinical
☐ Exercise Specialist
☐ Registered Clinical Exercise Physiologist
Other
☐ Please specify:

Highest Degree Earned Completion year: _____

If High School Diploma highest degree earned, does your education qualify you for your profession? ☐ Yes ☐ No

Section III: Employment/Occupation Information (Please furnish copy of licensure/certification)

Category (One Item Must Be Selected)**:**

- ☐ Employed
- ☐ Self-employed Full Time (25 hours or more/week)
- ☐ Self-employed Part Time (less than 25 hours per week)

Occupational Category (Check all that apply):

- ☐ Physical Therapist
- ☐ Physical Therapist Assistant
- ☐ Occupational Therapist
- ☐ Exercise Physiologist
  - ☐ Clinical
  - ☐ Non-Clinical
- ☐ Applied Physiology
  - ☐ Clinical
  - ☐ Non-Clinical
- ☐ Physical/Health Education
- ☐ Sports Medicine Instructor and Therapist
- ☐ Dance Therapist
- ☐ Dance Therapist Assistant
- ☐ Recreational Therapist
- ☐ Athletic Trainer
  - Do you provide services to professional athletes whose annual income is $100,000 or higher?
  - ☐ Yes ☐ No
- ☐ Adaptive Fitness Specialist
- ☐ Aerobics Instructor
- ☐ Cert Fitness/Personal Trainer
- ☐ Fitness Therapist Trainer
- ☐ Fitness Therapist Trainer Assistant
- ☐ Fitness Therapist
- ☐ Youth Fitness Trainer
- ☐ Wellness Coaching
- ☐ Executive, Corporate and Life Coaches
- ☐ Health Coaches

Number of years applicant has been practicing? _____

Projected Annual Gross Revenue from Services Rendered ($): _____

If Applying for Company Coverage, fill out below

Do any of those applying for coverage have any ownership interest in the firm? ☐ Yes ☐ No

If Yes, what percentage?

Provide the number of instructors to be insured:

Employee Names
1.) _____
2.) _____
3.) _____
4.) _____
5.) _____
6.) _____

By which credentialing organization are you certified? _____

Are you able to work in your state without licensure or certification? ☐ Yes ☐ No

Are you licensed? ☐ Yes ☐ No

If "Yes" selected above, by whom? _____

Section IV: Coverage

Please indicate applicable limit options you desire indications for (please note the limit selection will apply for both General & Professional Liability):

Per Occurrence/Policy Term Aggregate

- ☐ $500,000/$1,000,000
- ☐ $1,000,000/$1,000,000
- ☐ $1,000,000/$3,000,000
- ☐ $2,000,000/$4,000,000

Do you currently purchase professional liability insurance through the ACSM program?
☐ Yes ☐ No

If "Yes" selected from above, please provide the following
Current Policy Number: _____ Expiration Date: _____

If "No" selected from above, are you currently insured for professional liability through another carrier/plan?
☐ Yes ☐ No

If "Yes" selected from above, please provide the following
Current Policy Number: _____ Expiration Date: _____ Carrier: _____

Is the current coverage: ☐ Claims Made ☐ Occurrence

If "Claims Made" selected from above, provide the First Date of Continuous Coverage: _____

Do you wish to purchase coverage back to your first date of purchase for an additional premium? ☐ Yes ☐ No
Note: The limit for this option would is the same as coverage amount applied for above.

If Yes, please attach proof of coverage.

If No, please be advised that a claim occurring prior to the effective date of this policy will not be considered for coverage.

Section V: Warranty Questions

Have you ever had your license, certification or registration revoked? ☐ Yes ☐ No

Have you had any complaints or charges brought against you by any licensing board or professional ethics body?
☐ Yes ☐ No

Have you ever been convicted of a felony? ☐ Yes ☐ No

Have you ever had your professional liability insurance cancelled or non-renewed?
☐ Yes ☐ No

Have you ever had a claim or suit for alleged malpractice made against you, or are you aware of any incident that might reasonably lead to such a claim or suit? ☐ Yes ☐ No

Section VI: Comments

If desired, provide comments regarding this application: _____

_____

_____

_____

Section VII: Signature

Applicant represents and warrants to the best of their knowledge that the particulars and statements contained in this application are true and agree that these particulars and statements are the basis of the policy that may be issued, and will constitute a part of the policy. By Submitting this Application, the applicant agrees that in the event the application contains misrepresentations or fails to state facts materially affecting the risk assumed by the insuring company under a policy issues, the policy may be deemed null and void.

Name

Signature

Date

Please fax this form and copies of related licenses and/or certifications to 816.968.0600.