



## Student Professional Liability Insurance Occurrence Application

159 East County Line Road, Hatboro, PA 19040-1218 • Toll-Free #: 1-800-982-9491 • Fax #: 1-800-739-8818

**GUARANTEED ACCEPTANCE FOR ALL ELIGIBLE STUDENTS!**

**PLEASE PRINT CLEARLY AND COMPLETE THE FOLLOWING:**

FS9F7

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

Home Address: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**YES!** I want up to **\$3,000,000** aggregate, up to **\$1,000,000** each claim  
 Student Professional Liability Insurance Protection. (17)

1. I am a Student\*\* studying to be a(n): \_\_\_\_\_  
(See back of application for a list of professions and rates. Please PRINT your classification above.)

*\*\*If you are already a licensed professional or a recent graduate, please call 1-800-982-9491 for the appropriate application.*

2. Name of School \_\_\_\_\_ Anticipated Graduation Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

3. Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

4. Requested Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR  
 (Must be within 60 days from the date we receive your application. If date indicated is prior to receipt date or if not filled out, the effective date will be the receipt date.)

5. Are you a member of a Professional Association? .....  Yes  No

Name of Association(s): \_\_\_\_\_

**Insurance Agent: Michael J. Loughran Iowa License# IA241616; Florida License# A158896**

Payment Options:  **Send No Money Now** — bill me later for my annual premium.  
**OR -- Need coverage right away?** Apply now at [www.hpso.com](http://www.hpso.com).

I have answered these questions to the best of my knowledge. I certify that I hold the highest credentials or standards appropriate for the healthcare profession for which I have applied as mandated by my state guidelines. I have not withheld any information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I understand that a state mandated surcharge will be added to my annual premium if I am a resident of NJ (1.4%), WV (0.55%) or FL (2.51%).

**FRAUD NOTICE -- WHERE APPLICABLE UNDER THE LAW OF YOUR STATE**

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York Residents only; 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.) (For Pennsylvania Residents only; and subjects such a person to criminal or civil penalties.) (For Tennessee Residents only; Penalties include imprisonment, fines and denial of insurance benefits.)

**SIGNATURE: X** \_\_\_\_\_ **DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

**THIS APPLICATION MUST BE FULLY COMPLETED, SIGNED AND DATED IN INK. WE WILL ISSUE YOUR CERTIFICATE OF INSURANCE UPON APPROVAL.**

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Please see reverse side for compensation disclosure information

**QUESTIONS? Call Toll-Free 1-800-982-9491**



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