

**WELLNESS PAK PROGRAM APPLICATION**  
**General and Professional Liability**

**NOTE:** To add Commercial Property, Crime or Inland Marine, attach appropriate ACORD applications or equivalent.

**APPLICANT INFORMATION**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Policy Term \_\_\_\_\_  
Telephone \_\_\_\_\_ Professional License Type and Number (if required) \_\_\_\_\_

Business Organization:  Individual  Partnership  Corporation  Other \_\_\_\_\_

GL & Prof. Limits Requested: Occurrence \_\_\_\_\_ Personal Injury/Advertising \_\_\_\_\_  
General Aggregate \_\_\_\_\_ Medical Payments \_\_\_\_\_  
Prods/Comp Ops Aggregate \_\_\_\_\_ Fire Legal \_\_\_\_\_

Estimated annual payroll \$ \_\_\_\_\_ Estimated annual receipts \$ \_\_\_\_\_ Years in business \_\_\_\_\_

List full names of all individuals or partners and their interests.

Applicant is:  In private practice  An employee  Service contractor - List employer or principal under contract \_\_\_\_\_

Check services and procedures provided:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Aide or Assistant         | <input type="checkbox"/> Dietician/Nutritionist | <input type="checkbox"/> Social Work                      |
| <input type="checkbox"/> Audiology                 | <input type="checkbox"/> Guidance Counseling    | <input type="checkbox"/> Therapy (Occupational or Speech) |
| <input type="checkbox"/> Clergy                    | <input type="checkbox"/> Hospice Care           | <input type="checkbox"/> Marriage Counseling              |
| <input type="checkbox"/> Denturist                 | <input type="checkbox"/> Private Counseling     | <input type="checkbox"/> Occupational Counseling          |
| <input type="checkbox"/> Other (Be Specific) _____ |   |   |

Indicate the number of: \_\_\_\_\_ Annual outpatient visits \_\_\_\_\_ Professional employees \_\_\_\_\_ Participants

Describe all professional training, licensing or certification requirements achieved, memberships in professional organizations \_\_\_\_\_

**THREE YEAR LOSS EXPERIENCE**

<u>Date</u>	<u>Losses (description and amounts paid and incurred)</u>
_____	_____
_____	_____
_____	_____

Comments \_\_\_\_\_

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Producer Name & Address

**COVERAGE IS NOT BOUND UNTIL APPROVED BY THE COMPANY**