AAUP PROFESSIONAL LIABILITY INSURANCE PLAN APPLICATION

CLAIMS-MADE PROFESSIONAL LIABILITY

Underwritten By: Liberty Insurance Underwriters Inc.

HOW TO APPLY:

1. Complete application below.
2. Note the premium below for the policy you selected. All premiums are annual.
3. Return your completed application, along with your annual premium, to the address provided.
Coverage is effective the date your application is approved and payment is received. Please allow three to four weeks for delivery of your policy.
Please print or type all information.

NOTICE: THIS POLICY FOR WHICH THIS APPLICATION IS BEING SUBMITTED IS A CLAIMS-MADE POLICY, AND SUBJECT TO ITS TERMS AND CONDITIONS, THIS POLICY ONLY COVERS CLAIMS FIRST MADE AGAINST THE INSUREDS AND REPORTED TO THE INSURER IN WRITING DURING THE POLICY PERIOD, OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE.

CLAIMS EXPENSES REDUCE THE LIMIT OF LIABILITY. THIS COULD RESULT IN THE LIMIT OF LIABILITY BECOMING COMPLETELY EXHAUSTED BY THE PAYMENT OF CLAIMS EXPENSES, IN WHICH CASE, NO FURTHER COVERAGE IS PROVIDED BY THIS POLICY.

IF YOU ARE A RESIDENT OF MASSACHUSETTS, NEW HAMPSHIRE, NEW YORK, OKLAHOMA, OR SOUTH DAKOTA PLEASE CONTACT OUR OFFICE FOR THE CORRECT APPLICATION.

Complete the information requested below – please print or type:

LAST NAME	FIRST NAME	MIDDLE INITIAL	DOB (Date of Birth)

MAILING ADDRESS	CITY	STATE	ZIP

BUSINESS PHONE	FAX #	HOME PHONE#	E-MAIL ADDRESS

NAME OF THE EDUCATIONAL FACILITY FOR WHICH YOU WORK	YOUR PROFESSIONAL TITLE (I.E., TEACHER, LIBRARIAN)

Choose your Limit of Liability and Annual Premium Amount Due: *(please check one box)*

	Total Amount Due
☐ **PLAN I** – $500,000 each claim/$500,000 annual aggregate	**$ 75.00**
☐ **PLAN II** – $1,000,000 each claim/$1,000,000 annual aggregate	**$ 125.00**
☐ **PLAN III** – $1,000,000 each claim/$3,000,000 annual aggregate	**$ 140.00**
☐ **PLAN IV** – $2,000,000 each claim/$4,000,000 annual aggregate	**$ 170.00**

BE SURE TO COMPLETE ALL PAGES AND SIGN LAST PAGE

Underwriting Questions:

NOTE: If you are not an employee of an Educational Institution, you will not be eligible for coverage. If the answer to any of the questions below is "yes", please provide a detailed explanation in the space provided. If more space is needed, please provide complete detail by attachment, including dates, if applicable.

1. Are you currently a faculty member? ☐Yes ☐No
(Your main duties are as a teacher and/or researcher at a college or university)

2. Are you aware of any circumstance which may result in a claim being made against you? ..... ☐ Yes ☐No

3. During the past five years have any claims ever been made, or is any claim now pending, against you? ..... ☐ Yes ☐No

4. Has your license or certification to teach ever been suspended or revoked? ..... ☐ Yes☐ No

5. Have you ever been disciplined, suspended, or dismissed from employment for cause? ..... ☐Yes ☐No

6. Have you carried this type of similar insurance over the past three (3) years? ☐Yes ☐No

7. Have you ever had your Professional Liability insurance denied, cancelled, or non-renewed (other than due to loss of market)*?
☐ Yes ☐ No *Notice to Missouri Residents: This question does not apply

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I understand that I am not covered by this insurance while I am acting as any one of the following: Principal, Dean, Superintendent, other management staff, guidance counselor, nurse, psychologist, speech pathologist, physical therapist, dietician, occupational therapist or members of similar professions or administrative personnel. I understand that these professional occupations are excluded from the coverage.

YOU MUST SIGN AND DATE THE APPLICATION

IN ALL STATES OTHER THAN THOSE LISTED BELOW: 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 information, or conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

ARKANSAS, LOUISIANA, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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 information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK: 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 information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, 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.

Declaration and Signature -

The undersigned, on behalf of all prospective insureds, after a reasonable inquiry, declares to the best of his/her knowledge and belief that the statements contained herein are and are the basis of the acceptance of the risk or the hazard assumed by the Insurer under this Policy. It is further agreed by the undersigned, its Subsidiaries and their directors, officers and trustees that the Policy, if issued, is in reliance upon the truth of such representations. It is agreed that, although the signing of the Application does not commit the undersigned to purchase the insurance being applied for, the statements made in this Application shall become the basis of the Policy should one be purchased. The Insurer is hereby authorized to make any investigation and inquiry in connection with this application deemed necessary.

_____ _____ _____ / _____ / _____
Signature of Authorized Partner / Officer/Owner Title Date

_____
Name of individual signing this application (printed)

_____ _____ _____ / _____/ ___ ___
Producer's Signature **Producer's License Number** **Date**

_____
Producer's Name

Coverage is underwritten by Liberty Insurance Underwriters, Inc., and offered through Association Member Benefits Advisors, LLC.

Coverage begins upon approval of your application and receipt of your premium payment.

Enclosed is my check for $_____Effective Date Desired*_____
Make check payable to AMBA and return your check and this application in the envelope provided.
*May not be earlier than the date the administrator receives and approves this application.

If you choose to pay by credit card, visit www.ambasecureservice.com/33 to enter your credit card information and upload this form*. Submission of your credit card information to AMBA does not constitute receipt of payment or approval or binding of coverage by the insurer. Any coverage is subject to the terms and conditions of the insurance policy issued by the insurer.

Payment will be processed upon review and acceptance of your submission.
**Credit card payments are not accepted by email or fax.*

AMBA

Administrator:
Brad J. Feller, Principal
Association Member Benefits Advisors, LLC
PO Box 850179
Minneapolis, MN 55485-0179
1-800-503-9230

Underwritten by:
Liberty Insurance Underwriters, Inc.

AMBA Insurance Compensation & Disclosure

In accordance with industry custom, Association Member Benefits Advisors (in California DBA: Association Member Benefits & Insurance Agency) is compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. These commissions are used to fund enrollments, ongoing servicing, billing, marketing, customer administrative and claim servicing, and communications. Our compensation may vary depending on the type of insurance purchased and the insurer selected.

LIBERTY INSURANCE UNDERWRITERS INC.

(A New York Stock Insurance Company, hereinafter the "Company")

RHODE ISLAND - CONSENT TO CLAIMS EXPENSES WITHIN LIMITS

CLAIMS EXPENSES INCURRED UNDER THIS POLICY ARE PART OF AND NOT IN ADDITION TO THE LIMITS OF LIABILITY OF THIS POLICY. IN THE EFVENT THE LIMITS OF LIABILITY OF THIS POLICY ARE EXHAUSTED BY PAYMENT OF LOSS, THE COMPANY IS NOT LIABILE FOR FURTHER CLAIMS EXPENSES OR FOR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT.

I ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED THAT UNDER THIS POLICY AS WRITTEN, CLAIMS EXPENSES ARE INCLUDED WITHIN, AND MAY EXHAUST THE LIMITS OF LIABILITY OF THIS POLICY AND BY SIGNING THIS FORM, DO CONSENT TO THIS POLICY PROVISION.

_____

Policyholder/ Applicant Signature

_____

Print Name

_____

Date