

Mail Completed Application To:
CM&F Group, Inc.
 99 Hudson Street, 12th Floor
 New York, New York 10013-2815
 (212)233-8911 (800)221-4904
 Fax (212)608-4378
 info@cmfgroup.com

Underwritten By:
Granite State Insurance Company
 (A Capital Stock Company)
 2704 Commerce Drive, Suite B
 Harrisburg, PA 17110

**GENERAL HEALTHCARE PROVIDER PROFESSIONAL LIABILITY
 Attend Pro Application**

Producer Code _____

1. First Name _____ Middle Initial _____ Last Name _____

Just Like Family Home Care
 950 Encore Way, Suite #101
 Naples, FL 34110

2. How did you hear about us?
 Convention Colleague Advertisement Mail CM&F Group Website Association (Please List) Other

3. Please indicate your profession: Nurses Aide Home Healthcare Aide Certified Nurse Assistant (CNA) Other

4. Please indicate Limits of Liability desired (please check one): \$500,000/\$1,000,000 \$1,000,000/\$6,000,000

Are you an Indiana Resident electing to participate in the Indiana Patient's Compensation Fund? Yes No
 If yes, your Limit of Liability will be \$250,000/\$750,000

5. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had your professional privileges suspended by any court or administrative agency or ever been the subject of any ethics investigation at a local, state or national level?
 Yes No If yes, please attach a separate sheet with full particulars

6. Has any insurance ever been cancelled or non-renewed?
***NOTE: Missouri Residents Do Not Respond.** Yes No

7. Has any malpractice claim or suit ever been brought against you? Yes No If yes, please attach a separate sheet with full particulars.

8. 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, please attach a separate sheet with full particulars.

9. Please list your prior professional liability insurance, if any.

INSURANCE CARRIER	POLICY NUMBER	LIMITS	PREMIUM	EFFECTIVE DATES

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

The earliest effective date in which a policy can be issued is the date this application is received in our office.

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO VERMONT APPLICANTS: 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Applicant's Signature: _____

Title: _____ Date: _____

Name of Agent: _____ Submitted by: _____ Date: _____

Address: _____

Florida Agent License #: _____ California Agent License #: _____

74833 (1/00)

PREPAYMENT REQUIRED

Check or money order enclosed. Charge premium to credit card.

I authorize CM&F Group, Inc. to charge the premium to my:

VISA MASTERCARD

Credit Card Account Number: _____ Expiration Month and Year: _____

Print name exactly as it appears on card: _____

THIRD PARTY CREDIT CARD AUTHORIZATION

Please complete the following (if payer other than applicant):

CHARGE TO: VISA MASTERCARD

Credit Card Account Number: _____ Expiration Month and Year: _____

Card Member Name (Print): _____

Signature: _____ Date Signed: _____

MAIL TO: CM&F Group, Inc.

99 Hudson Street, 12th Floor, New York, NY 10013
212.233.8940 1.800.221.4904 FAX: 212.608.4378
nurse@cmfgroup.com

Florida Applicants:

Richard J.J. Sullivan, Jr. Non Resident License #A257825

California Applicants:

CMF Group, Inc. Non Resident CA License #OC3688713