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

74833 (1/00)

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

Producer Code ______________

GENERAL HEALTHCARE PROVIDER PROFESSIONAL LIABILITY
Nurse Guard Application

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: ☐ RN ☐ LPN/LVN
**I understand that if I am a Nurse Anesthetist or Certified Nurse Midwife, I am not covered by this policy.*
4. Please indicate Limits of Liability desired (please check one): ☐ $500,000/$1,000,000 ☐ $1,000,000/$6,000,000 ☐ $2,000,000/$4,000,000
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 #: ______________________

74836 (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
info@cmfgroup.com

Florida Applicants:
Richard J.J. Sullivan, Jr. Non Resident License #A257825

California Applicants:
CMF Group, Inc. Non Resident CA License #0C3688713