BEALS
Insurance Group

Protects your interests first and foremost.

555 Marin Street, Suite 180
Thousand Oaks, CA 91360
FAX: (805) 379-2522

PLEASE PRINT CLEARLY AND COMPLETE THE FOLLOWING:

Name: _____
Home Address: _____
City: _____
State: _____ Zip code: _____

Day Telephone #: _____
Night Telephone #: _____
Fax #: _____
E-mail: _____

Please answer ALL and SIGN and DATE this application. Incomplete applications cannot be processed.

1. Please choose your profession from the choices below. Next, enter your state of residency. Part time is 24 hours or less per week.

☐ Medical Assistant
☐ Phlebotomist

☐ Self Employed/Full Time
☐ Self Employed/Part Time

State of Residency: _____

2.

My primary are of work is (choose one):

☐ Ambulatory Care Facility (01)	☐ Home Health (05)	☐ Nursing School (09)	☐ Surgicenter (13)	☐ Research Center (18)
☐ Comm. Health Agency (02)	☐ Hospice (06)	☐ Prison (10)	☐ My own premises (14)	☐ Industry (19)
☐ Doctor's Office/Clinic (03)	☐ Hospital (07)	☐ School (11)	☐ Outpatient Facility (16)	☐ Fire/Rescue Station (20)
☐ HMO/PPO (04)	☐ Nursing Home (08)	☐ Staffing Agency (12)	☐ Health & Wellness Center (17)	☐ Rehab Facility (21)
☐ Other:_____				

3. Social Security #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ (MONTH / DAY / YEAR)

4. Requested Effective Date: _____ / _____ / _____ (MONTH / DAY / YEAR) (Must be within from the date we receive your application. If date indicated is prior to receipt 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: _____

6. Have you ever had professional liability insurance declined, canceled or non-renewed for any reason other than non-payment of premium? (Not applicable for MO residents)..... ☐ Yes ☐ No

7. Has any claim or lawsuit for malpractice ever been brought against you are you aware of any incidents that may result in a claim or lawsuit?..... ☐ Yes ☐ No

8. Within the last 5 years, have you been the subject of complaints, charges, or disciplinary action against you for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of your profession?..... ☐ Yes ☐ No

(If you have answered "yes" to questions 6, 7 or 8, please provide complete details on a separate sheet of paper and attach to application.)

Agent/Broker Information:
Agency Name: Beals Insurance Group
Address: 555 Marin Street, Suite 180 **City:** Thousand Oaks **State:** California **Zip Code:** 91360
Telephone: (805) 379-2022 **Fax:** (805) 379-2522 **Email:** docs@bealsagency.com .

Simple Enrollment

1. Complete all pages.
2. Print your name, sign and date in ink.
3. Send **all pages** of the application. We cannot process if **all pages** are not received.

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 information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete this insurance. It is agreed that this Application shall be on file with the Company and that it shall be deemed to be attached to and made part of the policy, if issued, as if physically attached to the policy. I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my insurance coverage. This application will be the basis of the contract if a Certificate of Insurance is issued. Once approved, I understand that there is no coverage in force until the premium is paid in full. I understand that a state mandated surcharge will be added to my annual premium if I am a resident of FL: (0.85%), KY (1.8%), NJ (0.70% or WV (0.55%). I have read and consent to the compensation terms below.

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 District of Columbia residents only: 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.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim one application continually false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information application for insurance is guilty of the crime and maybe subject to fines and confinement in prison.) (For Maine residents only: It is a crime to knowingly provide false, incomplete or misleading information into an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.) (For Maryland residents only: Any person who knowingly and willingly presents a false or fraudulent claim for payment of a loss or benefit more knowingly and willfully presents false information in an application for insurance is guilty of a crime and maybe subject to fines in confinement prison.) (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 Oklahoma residents only: 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 is guilty of a felony.) (For Pennsylvania residents only: 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.) (For Tennessee and Washington residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance for statement of claim containing any materially false or incomplete information, or conceal for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.)

Please Print Name _____

Applicant Signature _____ Date: ___ / ___ / ___
MONTH DAY YEAR

This application must be fully completed, signed and dated in ink. We will issue your certificate of insurance upon approval.

Please submit application by faxing the completed application to (805) 379-2522 or by emailing the completed application to docs@bealsagency.com.