NATE Membership & Professional Liability Insurance Program Personal Trainer Application

NATE exclusive package uses an American Massage Council Purchasing Group approved Master Policy.

Contact Data

Full Name (First, Middle, Last) _____ Practice Name _____

Office or Mailing Address (include Suite #) _____ City _____ State _____ Zip _____

Office Phone _____ Alternate Phone (Home, Cell, etc.) _____ Fax _____ Email _____

Cert. Current? ☐ Yes ☐ No

Personal Trainer Certification Number(s) _____ Issued By: ☐ NATE ☐ Other Personal Trainer School and Location _____ Year Graduated _____

Professional Information

1. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If *YES*, explain) ☐ Yes ☐ No
2. Has any agency or association investigated or taken any other action against you or your license / certification? (If *YES*, explain) ☐ Yes ☐ No
3. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If *YES*, explain) ☐ Yes ☐ No
4. Have you ever used any drug or substance that interfered with your ability to perform Personal Trainer duties? (If *YES*, explain) ☐ Yes ☐ No
5. Have you ever been charged with or convicted of any violation of the law other than a minor traffic offense? (If *YES*, explain) ☐ Yes ☐ No
6. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics, or make a differential diagnosis? (If *YES*, explain) ☐ Yes ☐ No
7. Have you ever provided Personal Trainer services for a professional athlete? (If *YES*, explain) ☐ Yes ☐ No
8. Do you provide any service other than as taught in the Personal Trainer schools? (If *YES*, explain) ☐ Yes ☐ No
9. List any other health designation you hold (RN, L.Ac, etc.) _____ Do you separately cover these for malpractice? ☐ Yes ☐ No
10. Who provides your current Personal Trainer malpractice coverage? _____ Policy Expires _____
11. Check here to add Blue Heron Academy as an additional insured at no additional cost: ☐
12. List any entity you want as an additional insured *($25 / entity)*: _____
13. Your Personal Trainer insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

Membership Options and Payment

Limits of Liability: $1,000,000 / $3,000,000

☐ 1st Year Professional @ $199.00 =	
☐ All Other Years @ $299.00 =	
☐ NATE Member. only (no ins.) @ $100.00	
☐ Additional Insured @ $25 per Entity =	
☐ General Liability @ $49.00 =	
☐ Business Personal Property @ $110 =	
($10,000 Limit - Lloyd's of London Policy – Incl. Tax)	
Total Payment Remitted	

Pmt Type: ❒ Check ❒MasterCard ❒Visa ❒AMEX

Card #: _____ Exp: _____

Fax or Mail Application To:

AHS (American Health Source)
2040 Raybrook SE, Suite 103
Grand Rapids MI 49546
P: 888-375-7245 F: 616-575-9066

Agreement & Signature

Professional & Premises Liability Coverage

NO FALSE STATEMENTS: I hereby apply for coverage. If provided, charge my credit card for the amount indicated. I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance, and that this declaration shall be a basis of, and form a part of, my policy.

CLAIMS-MADE ONLY *(Does not apply if your Claims Reporting Basis is Occurrence)*: I understand that if coverage is granted, the policy will only cover claims made during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless Extended Coverage is purchased within 30 days after termination.

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

SIGN: _____ **DATE:** _____