



PO Box 3870, Glen Allen, VA 23058-3870
(804) 527-2700 (800) 900-1155
Fax (804) 273-6144
www.markelfitness.com

Professional Liability Application for Fitness Instructors

(Program not available through insurance agents)

Important Note: All trainers and instructors must be currently certified by a national board recognized by Markel. This policy does not provide injury or damage coverage arising out of premises you own, rent, or occupy, or arising out of the sale of any type of product.

Mark your primary discipline needing professional liability: [] Aerobics [] Personal Trainer [] Yoga [] Pilates [] Dance [] Other

Your Name: _____

Business Name (if applicable): _____ [] Individual [] Corporation [] Partnership

Mailing Address: _____

City: _____ State: _____ Zip: _____

Business Phone: (____) _____ Home Phone: (____) _____

E-mail: _____ Web Site: _____

Have you ever applied for insurance with Markel? [] Yes [] No If Applicable, please provide policy number: _____

Name of facility where you work: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Does this facility require a certificate of insurance? [] Yes [] No Have you ever had a liability claim brought against you? [] Yes [] No (If Yes, attach a letter explaining all details.)

Program & Training Information

1. I have a current certification by: [] ACE [] ACSM [] AFAA [] ECA [] NETA [] NFPT [] W.I.T.S. [] Other

If Other: Organization Name: _____ Web Site: _____

2. Your current policy does not cover consulting or recommending dietary supplements. Do you want additional coverage for Nutritional or Diet counseling? [] Yes [] No If Yes, Please complete questions 2a and 2b. Please note: there is an additional premium. See premium charges below.

a. Do you have clients complete a health history form including all of the following: health conditions, allergies, and medications? [] Yes [] No

b. Do you have any training or education in nutrition? [] Yes [] No If Yes, what course? _____

3. Do you or your employer (if not self-employed) require a signed waiver from all clients? [] Yes [] No

If No, will you now require a signed waiver from all clients? [] Yes [] No

Please note: All records must be maintained for a minimum of 6 years. Please have the above forms available upon request.

4. In addition to professional fitness instruction, do you provide any of the following services/instruction?

- [] Martial Arts [] Sports Medicine [] Gymnastics [] Trampoline [] Tanning Devices
[] Body Wrapping [] Massage Therapy [] Physical Therapy [] Other Medical Treatments [] Chiropractic Treatments
[] Other (describe) _____

(If you have checked any of the above, contact us or your agent to obtain the appropriate coverage.)

Professional liability limit and coverage desired:

[] \$500,000 (Premium - \$185 fully earned) OR [] \$1,000,000 (Premium - \$200 fully earned)

[] Optional \$100,000 limit for Dietary Supplement Consulting (Premium - additional \$85 fully earned)

Coverage shall not be bound until the company approves the applicant's completed application and premium payment is received. The company's receipt of premium does not bind coverage until the completed application is also approved. In the event the company does not approve your application, your premium payment will be refunded.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Signed: _____ Date: ____/____/____

To charge full amount to MasterCard/VISA, please complete the following:

Credit Card Type: Visa MasterCard

Credit Card Number: _____ - _____ - _____

Expiration Date: ____/____

Cardholder Name: _____

(Please print)

Your Name: _____

(If different from Cardholder Name)

Cardholder Address: _____

City: _____ State: ____ ZIP: _____

Signature: _____

To pay full amount by check:

Please mail your payment, with your completed application, to:

Markel Insurance Company

Attn: Underwriting--Health & Fitness Unit

P.O. Box 3870

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