NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

SUPPLEMENT FOR MEDICAL ARTS SCHOOLS
(TO BE COMPLETED ALONG WITH THE ALLIED HEALTH GENERALAPPLICATION)

1. Name of Applicant: _____

2. Provide list of each class taught along with estimated number of students taught annually & length of class for each:

Type of Class Taught	Number of Students Annually	Length of Class
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Provide details of any externship programs offered including where they take place, duration, staff to student ratio & confirmation that students are supervised at all times & by whom:

_____

_____

4. Does the applicant verify that the facility(ies) where externships take place carry their own professional and general liability insurance with equal or greater limits?

Yes _____ No _____

Please enclose copies of any contractual agreements between the applicant & the facilities where the programs are conducted.

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Supplement must be signed by the owner or president or principal)