

**INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR ADVANCED PRACTICE NURSING PROFESSIONALS**

Broker ID # 31634 (Internal use only)
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**HOW TO APPLY:**

1. You may apply on-line at [www.proliability.com](http://www.proliability.com) or complete application below. (Please print or type all information)
2. Visit [www.proliability.com](http://www.proliability.com) for more information and to view available professions for applying online.
3. Note the annual premium below for the policy you selected.
4. Return your completed application, along with your annual premium, to the address provided.  
Coverage is effective the date your application is approved and payment is received.

**PLEASE CONTACT THE PROGRAM ADMINISTRATOR AT THE TOLL FREE NUMBER PROVIDED SHOULD YOU HAVE ANY QUESTIONS REGARDING THE LIMITS AND/OR OPTIONAL COVERAGES REFLECTED.**

Indiana residents only

Do you choose to participate in the Indiana Patient Compensation Fund (INPCF)?  Yes  No  
 If yes, provide average number of hours worked per week \_\_\_\_\_ and your Indiana license number. \_\_\_\_\_  
 Apply online at [www.proliability.com/faq](http://www.proliability.com/faq).

**NOTE:** Nurse Anesthetists, nurse midwives and those nurses involved in labor and delivery without the direct supervision of a physician, are not eligible for coverage. If you are a business owner and/or have employees or any independent contractors working on your behalf, please do not complete this application and instead visit [www.proliability.com/faq](http://www.proliability.com/faq) for the "Practice/Groups/Clinics" application.

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**Section A. APPLICANT INFORMATION (REQUIRED)**

First Name	Initial	Last Name	
Physical Street Address ((PO Boxes Not Allowed)	City	State	Zip
Mailing Address (IF DIFFERENT THAN ABOVE)	City	State	Zip
Business Phone #	Fax #	Home Phone #	
Date of Birth (MM/DD/YYYY)	Email Address	Effective Date Desired (MM/DD/YYYY)	

**Fully Owned dba or Corporation (If Applicable)**

**Note:** Businesses with employees and/or independent contractors, visit [www.proliability.com/faq](http://www.proliability.com/faq) for the "Practice/Groups/Clinics" application.

Are you an active member of a healthcare association?  Yes  No  
 If "Yes", please list the healthcare association:

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## Section B. PROFESSIONAL DESIGNATION

### Employed:

- A. You are an employee of an entity and receive IRS tax form W-2 (or an unpaid volunteer). You do not have ownership in an entity that issues your W-2 and/or performs professional services for which coverage is requested.
- B. Your Employer has a professional liability policy that does cover your work.

### Self-Employed:

- A. You either practice as an independent Solo Practitioner or as an Independent Contractor for which you receive an IRS tax form 1099 or your Employer pays your premium.
- B. You must select Self-Employed if you work for an Employer that you know at the time of application does not purchase professional liability or their policy does not cover your work. You must also complete questions 2 a-d in Section C.
- C. If you have or plan to hire employees and/or independent contractors and you wish to be insured for their actions, please apply as a firm. Visit [www.proliability.com/faq](http://www.proliability.com/faq) for the "Firm" application.
- D. If you work both Self Employed and Employed and would like to exclude from your coverage work you perform for **any** employer, please visit [www.proliability.com/faq](http://www.proliability.com/faq) for further information.

1. Select your professional designation:

<input type="checkbox"/> NP / <input type="checkbox"/> CNS (with prescriptive or medical diagnostic authority)
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2. Select your national certification (choose all that apply)

<input type="checkbox"/> Acute Care <input type="checkbox"/> Adult <input type="checkbox"/> Adult/Gerontology <input type="checkbox"/> Family <input type="checkbox"/> Gerontology <input type="checkbox"/> Neonatal <input type="checkbox"/> Oncology <input type="checkbox"/> Pediatric <input type="checkbox"/> Psychiatric & Mental Health <input type="checkbox"/> School <input type="checkbox"/> Women's Health
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a. Select primary area of specialty (choose one) then select your employment setting.

<b>Class 1:</b> <input type="checkbox"/> Adult <input type="checkbox"/> Family Planning <input type="checkbox"/> Gerontology <input type="checkbox"/> Women's Health <input type="checkbox"/> Oncology <input type="checkbox"/> Dermatology		
	Employed	Self Employed
	\$1,000,000 / \$6,000,000	\$1,000,000 / \$6,000,000
Full Time	<input type="checkbox"/> \$675	<input type="checkbox"/> \$811
Part Time (20hrs/wk. or less)	<input type="checkbox"/> \$507	<input type="checkbox"/> \$608
<b>Class 2:</b> <input type="checkbox"/> Psychiatric & Mental Health		
	Employed	Self Employed
	\$1,000,000 / \$6,000,000	\$1,000,000 / \$6,000,000
Full Time	<input type="checkbox"/> \$965	<input type="checkbox"/> \$1159
Part Time (20hrs/wk. or less)	<input type="checkbox"/> \$724	<input type="checkbox"/> \$869
<b>Class 3:</b> <input type="checkbox"/> Community Health <input type="checkbox"/> Family <input type="checkbox"/> Maternal & Child <input type="checkbox"/> Medical Surgical <input type="checkbox"/> Neonatology <input type="checkbox"/> Pediatric <input type="checkbox"/> Acute Critical Care (no OB/GYN) <input type="checkbox"/> School		
	Employed	Self Employed
	\$1,000,000 / \$6,000,000	\$1,000,000 / \$6,000,000
Full Time	<input type="checkbox"/> \$1255	<input type="checkbox"/> \$1506
Part Time (20hrs/wk. or less)	<input type="checkbox"/> \$941	<input type="checkbox"/> \$1129
<b>Class 4:</b> <input type="checkbox"/> OB/GYN <input type="checkbox"/> OB/GYN Acute Care <input type="checkbox"/> NP with Cosmetic		
	Employed	Self Employed
	\$1,000,000 / \$6,000,000	\$1,000,000 / \$6,000,000
Full Time	<input type="checkbox"/> \$1543	<input type="checkbox"/> \$1852
Part Time (20hrs/wk. or less)	<input type="checkbox"/> \$1543	<input type="checkbox"/> \$1852

Other limit options may be available upon request, please visit [www.proliability.com/faq](http://www.proliability.com/faq) for further instructions.

b. Select primary area of work (choose one)

<input type="checkbox"/> Ambulatory Care Facility <input type="checkbox"/> Community Health Agency <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital <input type="checkbox"/> Managed Care Organization <input type="checkbox"/> NP Owned Practice <input type="checkbox"/> Nursing Home <input type="checkbox"/> Physician Office <input type="checkbox"/> School <input type="checkbox"/> School/Education <input type="checkbox"/> Facility <input type="checkbox"/> Staffing Agency <input type="checkbox"/> Surgical Center
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**Section C. UNDERWRITING QUESTIONS**

1. **All Applicants:** Within the last ten (10) years:  
**For all "YES" responses, attach an explanation on a separate sheet of paper, preferably on any letterhead you might use.**

- a. Have you been the subject of any disciplinary or investigative proceedings (including Medicaid billing inquiries) and/or been reprimanded by a governmental or administrative agency, hospital or professional association?  Yes  No
- b. Have you been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No
- c. Have you had practice privileges reduced, suspended OR had a license or certification to practice revoked or denied?  Yes  No
- d. Has any state professional license to prescribe been refused, reduced, suspended, revoked, renewal refused, or accepted only on special terms or ever voluntarily surrendered?  Yes  No
- e. Has any claim or suit been brought against you or are you aware of any incident that might reasonably be expected to lead to a claim or suit?  Yes  No
- f. Have you had professional liability coverage refused, renewal denied, and/or cancelled\*?  Yes  No  
**\*Not applicable to Missouri residents.**
- g. Do you perform or assist in the performance of surgical procedures?  Yes  No  
 If Yes, please mark appropriate box below:
  - Minimally Invasive (any type of procedure less invasive than open surgery that typically involves local anesthesia, an incision requiring stiches or staples and covered with a bandage.)
  - \*\*Invasive Surgical Procedures** (Also referred to as "open surgery" is characterized as a procedure which "breaks" or perforates the skin or enters the body cavity under general anesthesia. This is typically characterized by the use of staples or stiches to close a much larger incision.)**\*\*Requires additional information, please complete the supplemental questionnaire attached to this application.**

2. **Self-Employed Applicants:** Please answer each question below  
**If you answer "YES" to any of the following questions, please visit [www.proliability.com/faq](http://www.proliability.com/faq) for further instructions.**

- a. Do you perform any services for or at a correctional facility?  Yes  No
- b. Do you independently interpret x-rays?  Yes  No
- c. Do you perform elective cosmetic procedures, including but not limited to micropigmentation, microdermabrasion, Botox or laser hair removal?  Yes  No
- d. Do you rent, sell, manufacture or distribute products?  Yes  No

**Section D. GENERAL LIABILITY**

*Locations must be owned or leased by the named insured. (Not available for brick and mortar practices.)*

Would you like to include the optional General Liability Coverage?  Yes  No

If "Yes", complete the section below and attach a separate sheet if necessary.

a. Owned or leased premises

Address	Own or Lease?
1.	
2.	
3.	

<b>Premium for General Liability</b>	<b>\$1,000,000 each incident \$6,000,000 annual aggregate</b>
Coverage for 1 <sup>st</sup> Location	<input type="checkbox"/> \$120
Each Additional Location	<input type="checkbox"/> \$50

**Section E. ADDITIONAL INSURED**

This coverage protects each facility under contract with the insured against claims arising out of the sole negligence of the insured. *It should only be purchased if required by contract.*

Would you like to include the optional Additional Insured Coverage?  Yes  No  
 If "Yes", complete the section below and attach a separate sheet if necessary.

A. Name, complete physical address of landlords or entities to be named as additional insureds with coverage type and business relationship for each facility.

1. Name _____ _____ Address _____ City _____ State _____ Zip _____ Business Relationship: _____	<input type="checkbox"/> Professional Liability ONLY <input type="checkbox"/> General Liability ONLY (GL coverage must be purchased) <input type="checkbox"/> Professional & General Liability (GL coverage must be purchased)
2. Name _____ _____ Address _____ City _____ State _____ Zip _____ Business Relationship: _____	<input type="checkbox"/> Professional Liability ONLY <input type="checkbox"/> General Liability ONLY (GL coverage must be purchased) <input type="checkbox"/> Professional & General Liability (GL coverage must be purchased)

<b>Premium for Additional Insured</b>	<b>\$1,000,000 each incident \$6,000,000 annual aggregate</b>
Professional Liability Only	<input type="checkbox"/> \$125
General Liability Only	<input type="checkbox"/> \$25
Professional & General Liability Only	<input type="checkbox"/> \$150

**Section F. PREMIUM CALCULATIONS**

\*If you are a resident of KY, have opted in to the VA statutory cap, or are participating in Indiana Patient Compensation Fund, please do not submit premium at this time. You will receive a quote from our Underwriting Department once your application is received and reviewed. For more information visit [www.proliability.com/faq](http://www.proliability.com/faq).

**Step 1. PREMIUM FROM SECTION B** \$ \_\_\_\_\_

**Step 2. RISK MANAGEMENT CREDIT (Sponsored Applicants Only)**

You will receive a one-time 10% premium credit if you complete or participate in one of the following:  
 Example: Premium selected x 90% = payment due (round to the nearest whole dollar).

- 1. Attend an approved loss prevention course/loss control/risk management seminar. The seminar must be at least four hours in length. The seminar credit will be on a per policy basis (one seminar, one credit, one annual policy period).
- 2. Hold an accepted certification from AANPCP, ANCC, AACN Certification Corporation or other certifying bodies.
- 3. Employment at a Magnet Hospital. Please list name of hospital: \_\_\_\_\_
- 4. Employment in a unit that has received the Beacon Award for Excellence.

Total RM credit cannot exceed 10 % \$ \_\_\_\_\_

**Step 3. SUBTOTAL steps 1 and 2** \$ \_\_\_\_\_

**Step 4. NON-DIRECT PATIENT CARE- Check here to add the endorsement**  **\$ 25.00**

This endorsement covers non-direct patient care services provided within your area of specialization as a Legal Consultant, Case Management, Expert Witness, Educational Services, Life Care Planning, Utilization Review, and Medical Administration. These services may not be covered under the policy without this endorsement. For more information visit [www.proliability.com/faq](http://www.proliability.com/faq).

Step 5. **OPTIONAL COVERAGES (section D and E IF APPLICABLE)** \$ \_\_\_\_\_

Step 6. **SUBTOTAL from Step 3 plus Step 4 & 5** \$ \_\_\_\_\_

Step 7. **PLUS APPLICABLE STATE TAXES OR SURCHARGES** \$ \_\_\_\_\_  
**NJ RESIDENTS ONLY: ADD .6% OF THE SUBTOTAL ABOVE FOR \*PLIGA SURCHARGE**  
**WV RESIDENTS ONLY: ADD .55% OF THE SUBTOTAL ABOVE FOR \*WV FIRE & CASUALTY SURCHARGE**

**\*PLIGA = NJ Property-Liability Insurance Guaranty Association Surcharge.** The New Jersey Insurance Commissioner has instructed all licensed property and casualty insurers, including Liberty Insurance Underwriters Inc., to pay assessments for the state NJ Property-Liability Insurance Guaranty Association Surcharge. The current surcharge amount is .6% of the total annual premium

**\*West Virginia Fire and Casualty Surcharge.** The West Virginia Insurance Commissioner has instructed all licensed property and casualty insurers, including Liberty Insurance Underwriters Inc., to pay assessments for the state West Virginia Fire and Casualty Surcharge. The current surcharge amount is .55% of the total annual premium.

**\*Kentucky residents: You may apply at: [www.proliability.com](http://www.proliability.com) and the appropriate taxes will be calculated – allowing you to purchase coverage and immediately produce a certificate of coverage.**

**Virginia residents only:** Information regarding participation in the VA Statutory Cap for Professional Liability set forth in Section 8.01-581.15 of the VA Code Ann. You have the option of participating in the above statutory cap; however by opting in, you understand that there will be a corresponding increase in premium and that this shall apply to all future renewals, reinstatements, rewrites or replacement policies issued by the Insurer unless otherwise requested by the Applicant in writing.

- Option One – increase my per incident/occurrence limit of liability annually until reaching the \$3,000,000 maximum in 2032:
- Option Two – In addition to increasing my per incident/occurrence limit of liability, I also want to increase my annual aggregate limit annually to be three times the per incident/occurrence limit:

**Please note that the available limit may be higher than the statutory cap. Please do not submit premium at this time. You will receive a quote from our Underwriting Department once your application is received and reviewed. We also offer coverage online, you can apply at: [www.proliability.com](http://www.proliability.com).**

Step 8. **PLUS RISK PURCHASING GROUP MEMBERSHIP FEE** \$ 2.00

"Risk Purchasing Group (RPG) membership fees are used to pay for expenses related to the management and administration of the RPG, including but not limited to RPG state filings and registrations, as well as the creation of risk management and risk avoidance education materials provided to RPG members. The RPG has entered into an administrative services agreement with an affiliated entity, Mercer Health & Benefits Administration, LLC ("Mercer"), for the management and administration of the RPG, and the RPG fees will be used to pay Mercer for the administrative services it provides to and on behalf of the RPG. Please note that the RPG membership fee is subject to change based on the effective date of your policy."

Step 9. **TOTAL PREMIUM DUE (ROUND TO NEAREST WHOLE DOLLAR)** \$ \_\_\_\_\_

I understand that I am not covered by this insurance for rendering or failure to render any professional services as a physician, surgeon, dentist, nurse midwife, perfusionist, cytotechnologist, chiropractor, podiatrist, osteopath or psychiatrist. I understand that these professional occupations are excluded from coverage. I understand that this insurance will not apply to any proprietor, owner, partner, manager, superintendent, or officer of any hospital, sanitarium, medical clinic, health maintenance organization, managed care facility, foster care agency, adoption agency, or any other facility not specified in the Declarations of the insurance policy. The insurance described herein is subject to the terms, conditions and exclusions of the insurance policy. This insurance is excess when other insurance applies to a loss.

In order to enhance the stability of this professional liability insurance program, coverage has been organized through a purchasing group, pursuant to legislation, known as the Federal Liability Risk Retention Act of 1986, enacted by Congress. Coverage is provided to the purchasing group by Liberty Insurance Underwriters Inc. ("Insurer"). This application is subject to the Insurer's underwriting rules and approval. Your completion of this application and premium payment does not bind coverage or obligate the Insurer to issue you insurance coverage. Coverage will become effective following the receipt of your acceptable application and premium payment. Your application cannot be processed unless it is completed in its entirety.

Once the completed application has been approved and the premium has been received, you will automatically become a member of a risk purchasing group operated by Mercer Consumer that is consistent with your professional designation.

## INSURANCE FRAUD WARNINGS

**IN ALL STATES OTHER THAN THOSE LISTED BELOW:** 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 may be a crime and may subject the person to criminal and civil penalties.

**ARKANSAS, LOUISIANA, RHODE ISLAND AND WEST VIRGINIA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DISTRICT OF COLUMBIA:** WARNING: 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.

**FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KANSAS:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**KENTUCKY:** 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 insurance act, which is a crime.

**MAINE, TENNESSEE, VIRGINIA AND WASHINGTON:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**MARYLAND:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NEW MEXICO:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**NEW YORK:** 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 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.

**OHIO:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA:** 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 information is guilty of a felony.

**PENNSYLVANIA:** 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.

**YOU MUST SIGN AND DATE THIS APPLICATION**

**Declaration and Signature -**

The undersigned declares to the best of his/her knowledge and belief that the statements contained herein are true and are the basis of the acceptance of the risk or the hazard assumed by the Insurer under this Policy. It is further agreed by the undersigned that the Policy, if issued, is in reliance upon the truth of such representations. It is agreed that, although the signing of the Application does not commit the undersigned to purchase the insurance being applied for, the statements made in this Application shall become the basis of the Policy should one be purchased. The Insurer is hereby authorized to make any investigation and inquiry in connection with this Application deemed necessary.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**APPLICANT Signature** **Date**

\_\_\_\_\_  
**Name of individual signing this application (printed)**

**Enclosed is my check for \$**\_\_\_\_\_  
*Make check payable to Mercer Consumer and return your check and this application.*  
May not be earlier than the date the Program Administrator receives and approves this application.

**If you choose to pay by credit card, visit [www.mercersecureservice.com/110](http://www.mercersecureservice.com/110) to enter your credit card information and upload this form\*. Submission of your credit card information to Mercer does not constitute receipt of payment or approval or binding of coverage by the insurer. Any coverage is subject to the terms and conditions of the insurance policy issued by the insurer. Payment will be processed upon review and acceptance of your submission.**  
*Note: Credit card payments are not accepted by email or fax.*

**Section Below For Producer/Agency Information Only**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Producer's Signature** **Producer's License Number** **Date**

\_\_\_\_\_  
**Producer's Name**



Program Administered by:  
Mercer Health & Benefits Administration LLC\*(“Mercer Consumer”)  
PO BOX 310395  
Des Moines, IA 50331-0395  
1-800-503-9230  
[www.proliability.com](http://www.proliability.com)

AR Insurance License #100102691  
CA Insurance License #0G39709  
Mark Brostowitz, Licensed Agent  
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

Underwritten by: Liberty Insurance Underwriters Inc.

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\*Mercer Consumer is a registered trade name of Mercer Health & Benefits Administration LLC

Surgical Procedures Supplemental Questionnaire

1. What surgical procedures are being performed, and what is your role? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are you performing or assisting the medical procedures on behalf on an entity?  Yes  No  
If yes, provide the location(s) at which the surgery is performed, the name, professional designation and licensure (if applicable) of the personnel performing and/or assisting in surgery, and their relationship to the entity.

Location(s)	Name	Professional Designation and (licensure, if applicable)	Relationship to entity

3. What percentage of services are derived from surgical procedures? \_\_\_\_\_



## **Mercer Consumer Insurance Compensation & Disclosure**

In this transaction, Mercer Consumer, a service of Mercer Health & Benefits Administration LLC, is acting as the exclusive insurance agent and program manager for Liberty Insurance Underwriters Inc. (Insurer) for this type of coverage, and not as your insurance broker. As the agent for Insurer, Mercer Consumer may provide these services: enrollments, ongoing servicing, billing, marketing, customer administrative and claim servicing and communications.

In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers or from other insurance intermediaries, which may be contingent upon such factors as volume, growth or retention of business. This compensation may include payment from insurers for marketing-related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation upon your request.

You may obtain this information by referring to <https://www.personal-plans.com/disclosure> and entering the security code o3975329 or call us at 1-888-206-5088 for specific details.

To review the applicable Liberty policy form, you may download it at our website: <https://www.proliability.com/lp/plpolicyforms/index.html>. Once you have been approved for coverage, you will also receive a complete packet of your policy documents.