NOVANT HEALTH

Dear Educational Institution Leader,

Thank you for your interest in sending qualified students to participate in clinical education experiences at Novant Health. We require this signed letter of agreement for all student experiences. Due to the volume of students, we are not able to make any changes to this agreement or sign any other agreements related to clinical education. As you have done in the past, please contact our Director of Student Programs regarding your educational needs. We cannot guarantee placement of any students, but will work with you to determine if we are able to accommodate your needs. The requirements for educational placements, including forms that must be signed by students and faculty, are available at http://www.NovantHealth.org/StudentPrograms .

Novant Health maintains ultimate responsibility for patient care. Students and faculty will not be used to provide services in place of Novant staff. Students and faculty are not employees and are not entitled to any compensation or benefits, including Workers' Compensation. Students will be provided information regarding our expectations of professionalism. While we hope that it will not be necessary, we reserve the right to ask a student to leave the premises immediately and exclude the student from further participation if he or she does not comply with our expectations or if we are concerned about safety or patient care. We will notify you promptly if this occurs. We will provide necessary feedback regarding the student's performance, with the School retaining ultimate responsibility for the learning experience, including grading. Novant Health is at all times responsible for administrative and professional supervision of students performing services under this Agreement and will provide appropriate, qualified professional clinical supervision for participating students. All of the requirements related to students also apply to faculty members who come on-site to our facilities. We require professional liability insurance to meet state specific coverage amounts but not less than $1,000,000 per occurrence and $3,000,000 annual aggregate. **Please include your certificate of insurance or insurance verification letter when you return a copy of this signed letter.** Novant provides this same level of insurance coverage for its employees assigned to the student's clinical education experience.

This agreement is for a one (1) year term and will automatically renew when we receive a copy of School's yearly certificate of insurance or insurance verification letter. Either party may terminate this agreement immediately for cause or upon thirty (30) days prior written notice without cause. Termination shall not prevent any student who is currently enrolled from completing the program. Both parties agree to comply with all applicable laws and regulations, including laws prohibiting discrimination. Thank you again for your interest in Novant Health. We look forward to partnering with you to prepare the next generation of health professionals.

Sincerely,

Debbie Kiser

Debbie Kiser
Vice President, Learning and Development

I HAVE READ AND AGREE WITH THE ABOVE INFORMATION.

Name	Charlie Hill Print Name	8-15-17 Date
Interim Associate VC Title	UW Oshkosh Educational Institution	

Please return with certificate of insurance to: Glenda Livengood, Fax: 336-277-6986, gslivengood@novanthealth.org, or Novant Health, 4020 Kilpatrick Street, Suite 203, Winston-Salem, NC 27104.

PROFESSIONAL LIABILITY INSURANCE PROGRAM – STUDENT APPLICATION

LICENSED/REGISTERED:

If you have passed your licensing examination and are licensed or registered, DO NOT use the form below.

Please contact the Administrator for an appropriate application, indicating your professional status.

Please print and complete all pages of this application.

RESIDENTS OF FLORIDA AND NEW JERSEY DO NOT COMPLETE THIS APPLICATION.
CONTACT ADMINISTRATOR FOR CORRECT APPLICATION.
IF YOU HAVE RECENTLY GRADUATED, YOU ARE NOT COVERED. PLEASE CALL (800) 503-9230 FOR CORRECT APPLICATION.

1. APPLICANT INFORMATION (Applicant Must Complete)

LAST NAME | FIRST NAME | INITIAL

SOCIAL SECURITY # | DATE OF BIRTH

HOME PHONE # | DAYTIME PHONE # | FAX # | E-MAIL ADDRESS

PERMANENT PHYSICAL STREET ADDRESS (MUST COMPLETE-NO PO BOXES) | CITY | STATE | ZIP

MAILING ADDRESS (IF DIFFERENT THAN ABOVE) | CITY | STATE | ZIP

FULL NAME OF SCHOOL | SCHEDULED DATE OF GRADUATION: MONTH/YEAR

ADDRESS OF SCHOOL | CITY | STATE | ZIP

CHECK TYPE OF STUDENT:

- ☐ Student Art Therapist
- ☐ Student Athletic Trainer
- ☐ Student Biomedical Technician
- ☐ Student Blood Bank Technologist
- ☐ Student Cardiology Technician
- ☐ Student Certified Laboratory Assistant
- ☐ Student Child Development and/or Family Services Counselor
- ☐ Student Clinical Laboratory Technologist
- ☐ Student Community Health Intern
- ☐ Student Counselor
- ☐ Student Dance Therapist
- ☐ Student Dental Assistant
- ☐ Student Dental Hygienist
- ☐ Student Dental Laboratory Technician
- ☐ Student Dietician (Non-ADA)*
- ☐ Student Drug and Alcohol Counselor
- ☐ Student EEG Technician
- ☐ Student EKG Technician
- ☐ Student Enterostomal Therapist
- ☐ Student Hemodialysis Technician
- ☐ Student Histologic Technician
- ☐ Student Hospital Pharmacist Technician
- ☐ Student Laboratory Aide
- ☐ Student Marriage and Family Counselor
- ☐ Student Massage Therapist
- ☐ Student Medical Assistant
- ☐ Student Medical Laboratory Technician
- ☐ Student Medical Technologist
- ☐ Student Music Therapist
- ☐ Student Nuclear Medical Technologist
- ☐ Student Occupational Therapist
- ☐ Student Occupational Therapist Assistant
- ☐ Student Optometric Technician
- ☐ Student Optometrist
- ☐ Student Orthopedic Technician
- ☐ Student Pastoral Counselor
- ☐ Student Personnel and/or Guidance Counselor
- ☐ Student Pharmacist
- ☐ Student Pharmacist Technician
- ☐ Student Phlebotomist
- ☐ Student Psychiatric Technician
- ☐ Student Psychologist
- ☐ Student Radiologic Technologist
- ☐ Student Recreational Therapist
- ☐ Student Rehabilitation Assistant
- ☐ Student Rehabilitation Counselor
- ☐ Student Respiratory Therapist
- ☐ Student Respiratory Therapy Technician
- ☐ Student Social Worker
- ☐ Student Surgical Technologist

☐ OTHER – If your specific curriculum is not listed, please indicate your course of study here_____
Explain and include a copy of the curriculum on a separate sheet of paper.

*If you are a member of ADA, please call administrator for appropriate application.

S.C. WWW

BE SURE TO COMPLETE ALL PAGES AND SIGN LAST PAGE ➡

2. PROFESSIONAL LIABILITY INSURANCE PROGRAM – STUDENT APPLICATION

LIMITS OF LIABILITY	PREMIUM – 1 YEAR	
$2,000,000 each incident/$4,000,000 annual aggregate	☐ $41.00	
$1,000,000 each incident/$3,000,000 annual aggregate	☐ $35.00	
MULTIPLE-YEAR CERTIFICATE OPTION	**PREMIUM – 2 YEARS**	**PREMIUM – 3 YEARS**
$2,000,000 each incident/$4,000,000 annual aggregate	☐ $80.00	☐ $115.00
$1,000,000 each incident/$3,000,000 annual aggregate	☐ $68.00	☐ $98.00

I understand that I am not covered by this insurance if I am any of the following, or a student of the following, or if I employ, or contract any of the following: physician, surgeon, dentist, sonographer, nurse midwife, chiropractor, podiatrist, osteopath, cytotechnologist, electroneurodiagnostic technologist, nurse anesthetist, perfusionist, psychiatrist, or any profession providing non-healthcare services. I understand that these professional occupations are excluded from coverage. I understand that this insurance will not apply to any partner, principal or owner of a residential/overnight facility. The insurance described herein is subject to the terms, conditions and exclusions of the insurance certificate. The 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 the Chicago Insurance Company, one of The Fireman's Fund Insurance Companies. Once the completed application has been approved and the premium has been received, you will automatically become a member of the Allied Health Purchasing Group Association, located and domiciled in Illinois and obtain the insurance coverage afforded through the Group Policy on an annual term.

This application is subject to the underwriter's approval. Your completion of this application and premium payment does not bind coverage or obligate the insurance company 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. The application is subject to the company's underwriting rules.

I declare the information contained in the application is true and that no material facts have been suppressed or misstated. I understand that incorrect information could void protection. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

New York Applicants: 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 that stated value of the claim for each such violation.

S.C. WWW

BE SURE TO COMPLETE ALL PAGES AND SIGN ➡

0000434-0000002-0000125

Transparency and Disclosure

Thank you for expressing your interest in the professional liability plans administered through Marsh Affinity. As part of Marsh Affinity's best practice, we are disclosing the following:

In this transaction, Marsh is acting as the insurance agent and program manager for Chicago Insurance Company ("Insurer") for this type of coverage, and not as your insurance broker. Comparable insurance products may be available in the insurance market place. Marsh is only offering this selected carrier quote proposal.

Marsh & McLennan Companies, Inc. and its subsidiaries own equity interests in certain insurers and have contractual arrangements with certain insurers and wholesale brokers. Information regarding such interests and contracts is available at http://global.marsh.com/about/Transparency.php

Marsh earns and retains interest income on premiums held by Marsh on behalf of insurers during the period between receipt of such payments from clients and the time such payments are remitted to the applicable insurer, where permitted by law.

The premium quoted includes up to 31.5% commission payable to Marsh. Your premium payment indicates your consent to this commission for this policy period and subsequent renewals, including any changes in commission rates at any such renewals.

Illinois Only - Illinois Medical Professional Liability Law PA94-677

Illinois Medical Professional Liability Law PA94-677, Senate Bill 475, requires insurers to implement a quarterly premium payment installment plan as prescribed by the Secretary of the Illinois Department of Financial and Professional Regulation (IDFPR).

If you practice in the state of Illinois and your annual medical professional liability premium is above $500, please visit www.proliability.com/illinstall for information regarding installment payment options.

Coverage is effective the date* your application and payment are received and approved in our offices unless another later date is shown here_____.
*Effective date may not be earlier than the date Marsh Affinity Group Services receives and approves this application.

YOU MUST SIGN AND DATE THIS APPLICATION

Signature _____ Date_____

Enclosed is my check for $_____ Effective Date Desired*_____

Make check payable to Seabury & Smith/Marsh and return your check and this application in the envelope provided.

*May not be earlier than the date the administrator receives and approves this application.

I authorize Seabury & Smith/Marsh to charge my: ☐ VISA ☐ MasterCard Amount $ _____

Credit Card Number _____ Expiration Date _____

Print name exactly as it appears on card _____

Administrator:

MARSH

Affinity Group Services
a service of Seabury & Smith
Joan F. O'Sullivan, Licensed Agent
75 Remittance Drive, Suite 1788
Chicago, IL 60675-1788
1-800-503-9230
www.proliability.com
CA License #0633005
d/b/a in CA Seabury & Smith Insurance Program Management

Underwritten by:
Chicago Insurance Company
One of the Fireman's Fund Insurance Companies®

S.C. WWW

PLE-STUDENT

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Professional Liability Insurance *for* Individual Students

Allied Health Sciences

Student Professional Liability Insurance Program

Professional Liability Insurance for Students is a Professional Necessity

Why You Need Professional Liability Insurance.

Responsibility. As your student responsibilities increase, so does you chance of being named in a lawsuit, regardless of the validity of the charges. As a student you are consistently exposed to clinical settings in which you could be held responsible for injuries to a patient or fellow student.

Vulnerability. Frivolous and unjustified claims are commonplace in today's courts. Professional Liability insurance is a necessary safeguard for any student healthcare professional.

What Makes Marsh Affinity Group Services Your Best Choice?

There is nothing more important than finding a reliable company to administer your insurance program.

More students trust Marsh Affinity Group Services for protection. You will have peace of mind knowing that Marsh Affinity Group Services is the oldest and most established insurance administrator for allied professional healthcare associations and societies. We have worked with allied healthcare schools and students since 1949.

The underwriter of this Program, Chicago Insurance Company, one of the Fireman's Fund Insurance Companies.

The Marsh Affinity Group Services Individual Professional Liability program offers you:

A Multiple-Year Certificate Option. The Marsh Affinity Group Services Program offers a Multiple-Year certificate and an associated premium credit if you choose to pre-pay. You may choose a 3-year or 2-year certificate. This option enables you to save money on your premium and gives you peace of mind knowing your coverage will not lapse from year to year; you may be covered for your entire educational experience.

Pays Up To $2,000,000/$4,000,000 Professional Liability Coverage. The insurance company may pay up to $2,000,000 per incident, or up to a total of $4,000,000 annual aggregate for covered claims arising from real or alleged negligence. *Few companies offer students limits this high.*

Expert Legal Counsel – At No Cost To You. Legal fees and court costs incurred by the insurer on your behalf are paid, for covered claims, in addition to the limits of liability, even if the suit is groundless, false or fraudulent.

With a nationwide network of experienced attorneys and claims adjusters, immediate support is available to you should a covered claim be threatened or filed against you. *Some other policies expect you to find your own legal defense.*

School Disciplinary Board/Grievance Committee Defense.

This insurance policy goes beyond providing protection for your professional acts as a student healthcare professional. It will reimburse you, up to $1,000 per policy period, for attorney fees and other costs resulting from the investigation and defense of proceedings before a school grievance committee or academic disciplinary board if the proceedings result from your provision of professional services.

Coverages Included At No Additional Costs!

- **First Aid Coverage.** If you render first aid to others outside of your educational program and incur expenses, the insurance will reimburse you up to $500 dollars annual aggregate.
- **First Party Assault Coverage.** The Program pays up to $1,000 annual aggregate for medical expenses resulting from bodily injury to you or damage to your personal property if assaulted. The assault must occur on the school's premises or the area immediately adjoining such school premises (i.e., the parking lot), or while you are away from school conducting an authorized school activity.

Also Include Supplemental Liability Coverage.

With supplemental liability coverage, subject to the terms of the insurance certificate, you are covered for bodily injury and property damage occurrences not related to your professional duties.

You are not covered for engaging in a business or a profession.

Apply Now For This Low-Cost Protection

Your certificate is effective on the date your application and payment are received and approved in our offices, unless you request a later effective date. Your effective date may not be earlier than the date the administrator receives and approves this application (Note, to meet a specific effective date your application should be submitted more than 90 days prior to the effective date desired.)

Advance enrollment. To receive your certificate by the date the verification of insurance is required, we suggest you apply approximately 60 days before that time.

Please allow 3 to 4 weeks for delivery of your certificate.

Administered by:

MARSH

Affinity Group Services
a service of Seabury & Smith

Joan F. O'Sullivan, Licensed Agent
75 Remittance Drive, Suite 1788
Chicago, IL 60675-1788
1-800-503-9230
www.proliability.com

CA License #0633005
d/b/a in CA Seabury & Smith Insurance Program Management

Underwritten by:
Chicago Insurance Company
One of the Fireman's Fund Insurance Companies®

This brochure contains a summary of the program provisions. If there is a conflict between this brochure and the actual certificate, the certificate language will dictate coverage.

 PLP-STUDENT

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