FSMTA Professional Liability Insurance Program
Personal Trainer Application

FSMTA 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 _____

Personal Trainer License Number(s) _____ State Issued _____ Date Issued _____ Personal Trainer School / College and Location _____ Year Graduated _____

Professional Information

1. Is your Personal Trainer license issued by: ☐ State ☐ City ☐ N/A, Is your personal trainer license current? (Attach Copy) ☐ Yes ☐ No
2. 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
3. Has any board, agency, association, or insurer investigated or taken any action involving you or your license / certification? (If *YES*, explain) ☐ Yes ☐ No
4. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If *YES*, explain) ☐ Yes ☐ No
5. Have you ever used any drug or substance that interfered with your ability to perform Personal Trainer duties? (If *YES*, explain) ☐ Yes ☐ No
6. 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
7. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics, or make a differential diagnosis? (If *YES*, explain) ☐ Yes ☐ No
8. Have you ever provided Personal Trainer services for a professional athlete? (If *YES*, explain) ☐ Yes ☐ No
9. Are you providing any personal trainer service that was not a part of your Personal Trainer school program? (If *YES*, explain) ☐ Yes ☐ No
10. List any other health designation you hold (RN, L.Ac, etc.) _____ Do you separately cover these for malpractice? ☐ Yes ☐ No
11. List any entity you want as an additional insured: _____
12. Your Personal Trainer insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

Coverage Options

Select your policy limits (includes both Professional & General liability), Rates quoted do not include FSMTA Membership. Limits chosen follow to additional profession massage coverage.

☐ $1,000,000 / $3,000,000	@ $242 =	
☐ $2,000,000 / $6,000,000	@ $350 =	
☐ Massage Additional Profession	@ $34 =	
☐ Business Personal Property ($10,000 Limit – Issued by Lloyd's of London)	@ $135 =	
TOTAL DUE:		

Payment Options

☐ Check ☐ Discovery ☐ MasterCard ☐ Visa ☐ AMEX

Card #: _____ Expires: _____

3 or 4 Digit Security Code: _____ Billing Zip Code: _____

Sign then Fax or Mail Application

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. I understand that this is a Claims Made policy which 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. 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, threats, or filings of lawsuits.

SIGN: _____ DATE: _____

SEND APPLICATION AND REMIT PAYMENT TO:

FSMTA

3820 Northdale Blvd., Suite 205A
Tampa, FL 33624
P: 407.786.3307 F: 813.422.7966
Email: info@fsmta.org - Web: www.fsmta.org