

Section Name	Field Name	Field and/or Section Description
TITLE ACORD 196 (2013/09)	Medical Professional Liability Insurance Application	The title of the form. ACORD 196, Medical Professional Liability Insurance Application, is used to apply for medical professional liability insurance coverage. ACORD 196 is a self-contained application. It is not necessary to use another ACORD form with this application, including ACORD 125, Commercial Insurance Application - Applicant Information Section or ACORD 825 Professional / Specialty Insurance Application (For Use in Management, Executive & Professional Lines - Applicant Section).
IDENTIFICATION SECTION	Date	Enter date: The date on which the form is completed.
IDENTIFICATION SECTION	Agency	Enter text: The full name of the producer/agency.
IDENTIFICATION SECTION	Agency Address	Enter text: The mailing address line one of the producer/agency.
IDENTIFICATION SECTION		Enter text: The mailing address line two of the producer/agency.
IDENTIFICATION SECTION		Enter text: The mailing address city name of the producer/agency.
IDENTIFICATION SECTION		Enter code: The mailing address state or province code of the producer/agency.
IDENTIFICATION SECTION		Enter code: The mailing address postal code of the producer/agency.
IDENTIFICATION SECTION		Enter identifier: The agency's state license number. As used here, this is required in Nebraska.
IDENTIFICATION SECTION	Contact Name	Enter text: The name of the individual at the producer's establishment that is the primary contact.
IDENTIFICATION SECTION	Phone	Enter number: The producer's contact person's phone number. If applicable, include the area code and extension.
IDENTIFICATION SECTION	Fax	Enter number: The fax number of the producer/agency.
IDENTIFICATION SECTION	Email Address	Enter text: The producer's contact person e-mail address.
IDENTIFICATION SECTION	Code	Enter code: The identification code assigned to the producer (e.g. agency or brokerage firm) by the insurer.
IDENTIFICATION SECTION	Sub Code	Enter code: The identification code assigned by the insurer to the sub-producer (e.g. person) within a producer's office (e.g. agency or brokerage).

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IDENTIFICATION SECTION	Agency Customer ID	Enter identifier: The customer's identification number assigned by the producer (e.g. agency or brokerage).
IDENTIFICATION SECTION	Carrier	Enter text: The insurer's full legal company name(s) as found in the file copy of the policy. Use the actual name of the company within the group to which the policy has been issued. This is not the insurer's group name or trade name.
IDENTIFICATION SECTION	NAIC Code	Enter code: The identification code assigned to the insurer by the NAIC.
IDENTIFICATION SECTION	Applicant (First Name Insured)	Enter text: The named insured(s) as it/they will appear on the policy declarations page.
IDENTIFICATION SECTION	Social Security #	Enter identifier: The tax identifier of the named insured.
IDENTIFICATION SECTION	DEA # (If Applicable)	Enter identifier: The identifier for the named insured assigned by the USA Drug Enforcement Agency.
IDENTIFICATION SECTION	US Citizen? Yes (Checkbox)	Check the box (if applicable): Indicates the named insured is a citizen of the United States of America.
IDENTIFICATION SECTION	US Citizen? No (Checkbox)	Check the box (if applicable): Indicates the named insured is not a citizen of the USA.
IDENTIFICATION SECTION	Date Of Birth	Enter date: The date of birth of the insured.
IDENTIFICATION SECTION	Primary Business Address	Enter text: The first address line of the physical location.
IDENTIFICATION SECTION		Enter text: The second address line of the physical location.
IDENTIFICATION SECTION		Enter text: The city of the physical location.
IDENTIFICATION SECTION		Enter code: The state or province of the physical location.
IDENTIFICATION SECTION		Enter code: The postal code of the physical location.
IDENTIFICATION SECTION	Phone	Enter number: The named insured's primary phone number.
IDENTIFICATION SECTION	Mailing Address	Enter text: The named insured's mailing address line one.
IDENTIFICATION SECTION		Enter text: The named insured's mailing address line two.

Section Name	Field Name	Field and/or Section Description
IDENTIFICATION SECTION		Enter text: The named insured's mailing address city name.
IDENTIFICATION SECTION		Enter code: The named insured's mailing address state or province code.
IDENTIFICATION SECTION		Enter code: The named insured's mailing address postal code.
COVERAGES / LIMITS	Claims Made (Checkbox)	Check the box (if applicable): Indicates the "coverage trigger" is on a claims-made basis on a medical professional liability policy.
COVERAGES / LIMITS	Occurrence (Checkbox)	Check the box (if applicable): Indicates the "coverage trigger" is on an occurrence basis on a medical professional liability policy.
COVERAGES / LIMITS	Aggregate (\$)	Enter limit: The liability aggregate limit amount.
COVERAGES / LIMITS	Each Occurrence (\$)	Enter limit: The liability each occurrence limit amount.
COVERAGES / LIMITS	Other (\$)	Enter limit: The coverage limit amount.
COVERAGES / LIMITS	Other Description	Enter text: The description of the coverage.
COVERAGES / LIMITS	Proposed Effective Date	Enter date: The effective date of the policy. The date that the terms and conditions of the policy commence. As used here, this is the proposed effective date.
COVERAGES / LIMITS	Proposed Retroactive Date	Enter date: The retroactive date you are requesting for the policy being applied for. This is the proposed earliest date for which an occurrence could "trigger" coverage under a Claims Made policy.
PROFESSION	Physician (Checkbox)	Check the box (if applicable): Indicates the named insured is a physician.
PROFESSION	Primary Practice	Enter text: The description of the primary practice of the physician.
PROFESSION	Secondary Practice	Enter text: The description of the secondary practice of the physician.
PROFESSION	Surgeon (Checkbox)	Check the box (if applicable): Indicates the named insured is a surgeon.
PROFESSION	Specialty	Enter text: The description of the surgeon's specialty.
PROFESSION	Other	Enter text: The description of the surgeon's other practice / specialty.
PROFESSION	Physician's Assistant (Checkbox)	Check the box (if applicable): Indicates the named insured is a physician's assistant.
PROFESSION	Nurse Anesthetist (Checkbox)	Check the box (if applicable): Indicates the named insured is a nurse anesthetist.
PROFESSION	Surgeon's Assistant (Checkbox)	Check the box (if applicable): Indicates the named insured is a surgeon assistant.
PROFESSION	Psychologist (Checkbox)	Check the box (if applicable): Indicates the named insured is a psychologist.
PROFESSION	Nurse Midwife (Checkbox)	Check the box (if applicable): Indicates the named insured is a nurse midwife.
PROFESSION	Perfusionist (Checkbox)	Check the box (if applicable): Indicates the named insured is a perfusionist.
PROFESSION	Registered Nurse (Checkbox)	Check the box (if applicable): Indicates the named insured is a registered nurse.
PROFESSION	Licensed Practical Nurse (Checkbox)	Check the box (if applicable): Indicates the named insured is a licensed practical nurse.
PROFESSION	Optometrist (Checkbox)	Check the box (if applicable): Indicates the named insured is an optometrist.

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PROFESSION	Emergency Medical Technician (Checkbox)	Check the box (if applicable): Indicates the named insured is an emergency medical technician.
PROFESSION	Nurse Practitioner (Checkbox)	Check the box (if applicable): Indicates the named insured is a nurse practitioner.
PROFESSION	Counselor (Checkbox)	Check the box (if applicable): Indicates the named insured is a counselor.
PROFESSION	Other (Checkbox)	Check the box (if applicable): Indicates the named insured's occupation is other than those listed.
PROFESSION	Other (Specify) Field	Enter text: The named insured's primary occupation or business activity.
PERSONAL INFORMATION	Type Of Certification Currently Held	Enter text: The description of certifications held by the named insured.
PERSONAL INFORMATION	State One	Enter code: The state or province issuing the license.
PERSONAL INFORMATION	License # One	Enter identifier: The license number.
PERSONAL INFORMATION	State Two	Enter code: The state or province issuing the license.
PERSONAL INFORMATION	License # Two	Enter identifier: The license number.
PERSONAL INFORMATION	State Three	Enter code: The state or province issuing the license.
PERSONAL INFORMATION	License # Three	Enter identifier: The license number.
EDUCATION	Institution One	Enter text: The name of the school or educational institution.
EDUCATION	Dates Of Attendance-Mo/Yr One-A	Enter date: The date (MM/YYYY) the named insured started attending the school or education institution.
EDUCATION	Dates Of Attendance-Mo/Yr One-B	Enter date: The date (MM/YYYY) the named insured stopped attending the school or education institution.
EDUCATION	Date Graduated One	Enter date: The date (MM/YYYY) the named insured graduated from the school or education institution.
EDUCATION	Certification Or Degree Received One	Enter text: The certification or degree received.
EDUCATION	Institution Two	Enter text: The name of the school or educational institution.
EDUCATION	Dates Of Attendance-Mo/Yr Two-A	Enter date: The date (MM/YYYY) the named insured started attending the school or education institution.
EDUCATION	Dates Of Attendance-Mo/Yr Two-B	Enter date: The date (MM/YYYY) the named insured stopped attending the school or education institution.

Section Name	Field Name	Field and/or Section Description
EDUCATION	Date Graduated Two	Enter date: The date (MM/YYYY) the named insured graduated from the school or education institution.
EDUCATION	Certification Or Degree Received Two	Enter text: The certification or degree received.
EDUCATION	Institution Three	Enter text: The name of the school or educational institution.
EDUCATION	Dates Of Attendance-Mo/Yr Three-A	Enter date: The date (MM/YYYY) the named insured started attending the school or education institution.
EDUCATION	Dates Of Attendance-Mo/Yr Three-B	Enter date: The date (MM/YYYY) the named insured stopped attending the school or education institution.
EDUCATION	Date Graduated Three	Enter date: The date (MM/YYYY) the named insured graduated from the school or education institution.
EDUCATION	Certification Or Degree Received Three	Enter text: The certification or degree received.
EDUCATION	List Continuing Education Courses And Credits Received Within Last 2 Years (Or Attach Copies Of Certificates And/Or Credits Received)	Enter text: The description of continuing education courses and credits received within the stated number of years.
EDUCATION	Has Your Certification/License In Any State Ever Been (Voluntarily Or Otherwise) Suspended, Denied, Revoked, Restricted Or Limited In Any Way? If Yes, Explain-YES (Checkbox)	Check the box (if applicable): Indicates a "Yes" response to the question, "Has your certification / license in any state ever been (voluntarily or otherwise) suspended, denied, revoked, restricted or limited in any way?".
EDUCATION	Has Your Certification/License In Any State Ever Been (Voluntarily Or Otherwise) Suspended, Denied, Revoked, Restricted Or Limited In Any Way? If Yes, Explain-NO (Checkbox)	Check the box (if applicable): Indicates a "No" response to the question, "Has your certification / license in any state ever been (voluntarily or otherwise) suspended, denied, revoked, restricted or limited in any way?".

Section Name	Field Name	Field and/or Section Description
EDUCATION	Has Your Certification/License In Any State Ever Been (Voluntarily Or Otherwise) Suspended, Denied, Revoked, Restricted Or Limited In Any Way? If Yes, Explain-Other Field	Enter text: An explanation as to whether the applicant's certification / license in any state has ever been (voluntarily or otherwise) suspended, denied, revoked, restricted or limited in any way.
EDUCATION	Current Practice (Describe General Duties And Extent Of Supervision (If Any)	Enter text: The description of the current practice including general duties and extent of supervision (if any).
EDUCATION	List Any Association/Society/Memberships Related To Your Profession	Enter text: The name of the affiliated organization(s) to which the individual has an affiliation. If no affiliation exists, indicates "none" or "not applicable".
EDUCATION		Enter text: The name of the affiliated organization(s) to which the individual has an affiliation. If no affiliation exists, indicates "none" or "not applicable".
EDUCATION		Enter text: The name of the affiliated organization(s) to which the individual has an affiliation. If no affiliation exists, indicates "none" or "not applicable".
EDUCATION		Enter text: The name of the affiliated organization(s) to which the individual has an affiliation. If no affiliation exists, indicates "none" or "not applicable".
EDUCATION		Enter text: The name of the affiliated organization(s) to which the individual has an affiliation. If no affiliation exists, indicates "none" or "not applicable".
EDUCATION	Present Employees And Positions	Enter text: The full name of the employee.
EDUCATION		Enter text: The title this person has in the current employment position.
EDUCATION		Enter text: The full name of the employee.
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EDUCATION		Enter text: The title this person has in the current employment position.
LOSS HISTORY	Chk Here If None (Checkbox)	Check the box (if applicable): Indicates there are no prior losses or occurrences that may give rise to claims for the mandated number of years.
LOSS HISTORY	See Attached Loss Summary (Checkbox)	Check the box (if applicable): Indicates that a loss summary report is attached to the application.

Section Name	Field Name	Field and/or Section Description
LOSS HISTORY	Date Of Occurrence One	Enter date: The date when the accident or incident occurred that resulted in the filing of a claim.
LOSS HISTORY	Type / Description Of Occurrence Or Claim One	Enter text: A brief description of the loss.
LOSS HISTORY	Date Of Claim One	Enter date: The date the claim was filed.
LOSS HISTORY	Amount Paid One	Enter amount: The amount that has been paid on this claim to date.
LOSS HISTORY	Amount Reserved One	Enter amount: The reserve amount the previous carrier is holding open for this claim.
LOSS HISTORY	Claim Status-Open (Checkbox) One	Check the box (if applicable): Indicates the claim is still open.
LOSS HISTORY	Claim Status-Closed (Checkbox) One	Check the box (if applicable): Indicates the claim is closed.
LOSS HISTORY	Date Of Occurrence Two	Enter date: The date when the accident or incident occurred that resulted in the filing of a claim.
LOSS HISTORY	Type / Description Of Occurrence Or Claim Two	Enter text: A brief description of the loss.
LOSS HISTORY	Date Of Claim Two	Enter date: The date the claim was filed.
LOSS HISTORY	Amount Paid Two	Enter amount: The amount that has been paid on this claim to date.
LOSS HISTORY	Amount Reserved Two	Enter amount: The reserve amount the previous carrier is holding open for this claim.
LOSS HISTORY	Claim Status-Open (Checkbox) Two	Check the box (if applicable): Indicates the claim is still open.
LOSS HISTORY	Claim Status-Closed (Checkbox) Two	Check the box (if applicable): Indicates the claim is closed.
LOSS HISTORY	Date Of Occurrence Three	Enter date: The date when the accident or incident occurred that resulted in the filing of a claim.
LOSS HISTORY	Type / Description Of Occurrence Or Claim Three	Enter text: A brief description of the loss.
LOSS HISTORY	Date Of Claim Three	Enter date: The date the claim was filed.
LOSS HISTORY	Amount Paid Three	Enter amount: The amount that has been paid on this claim to date.
LOSS HISTORY	Amount Reserved Three	Enter amount: The reserve amount the previous carrier is holding open for this claim.
LOSS HISTORY	Claim Status-Open (Checkbox) Three	Check the box (if applicable): Indicates the claim is still open.
LOSS HISTORY	Claim Status-Closed (Checkbox) Three	Check the box (if applicable): Indicates the claim is closed.
IDENTIFICATION SECTION	Agency Customer ID	Enter identifier: The customer's identification number assigned by the producer (e.g. agency or brokerage).

Section Name	Field Name	Field and/or Section Description
PRIOR CARRIER INFORMATION	Carrier One	Enter text: The name of the previous insurer.
PRIOR CARRIER INFORMATION	Policy Number One	Enter identifier: The policy number of the previous coverage.
PRIOR CARRIER INFORMATION	Policy Type-Claims Made (Checkbox) One	Check the box (if applicable): Indicates the "coverage trigger" is on a claims-made basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Policy Type-Occurrence (Checkbox) One	Check the box (if applicable): Indicates the "coverage trigger" is on an occurrence basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Retro Date One	Enter date: The retroactive date for the policy being described. This is the date for which an occurrence could "trigger" coverage under a Claims Made policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date One	Enter date: The effective date of the prior policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date One	Enter date: The expiration date of the previous coverage.
PRIOR CARRIER INFORMATION	General Aggregate One	Enter limit: The liability aggregate limit amount.
PRIOR CARRIER INFORMATION	Each Occurrence One	Enter limit: The liability each occurrence limit amount.
PRIOR CARRIER INFORMATION	Carrier Two	Enter text: The name of the previous insurer.
PRIOR CARRIER INFORMATION	Policy Number Two	Enter identifier: The policy number of the previous coverage.
PRIOR CARRIER INFORMATION	Policy Type-Claims Made (Checkbox) Two	Check the box (if applicable): Indicates the "coverage trigger" is on a claims-made basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Policy Type-Occurrence (Checkbox) Two	Check the box (if applicable): Indicates the "coverage trigger" is on an occurrence basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Retro Date Two	Enter date: The retroactive date for the policy being described. This is the date for which an occurrence could "trigger" coverage under a Claims Made policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date Two	Enter date: The effective date of the prior policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date Two	Enter date: The expiration date of the previous coverage.
PRIOR CARRIER INFORMATION	General Aggregate Two	Enter limit: The liability aggregate limit amount.
PRIOR CARRIER INFORMATION	Each Occurrence Two	Enter limit: The liability each occurrence limit amount.

Section Name	Field Name	Field and/or Section Description
PRIOR CARRIER INFORMATION	Carrier Three	Enter text: The name of the previous insurer.
PRIOR CARRIER INFORMATION	Policy Number Three	Enter identifier: The policy number of the previous coverage.
PRIOR CARRIER INFORMATION	Policy Type-Claims Made (Checkbox) Three	Check the box (if applicable): Indicates the "coverage trigger" is on a claims-made basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Policy Type-Occurrence (Checkbox) Three	Check the box (if applicable): Indicates the "coverage trigger" is on an occurrence basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Retro Date Three	Enter date: The retroactive date for the policy being described. This is the date for which an occurrence could "trigger" coverage under a Claims Made policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date Three	Enter date: The effective date of the prior policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date Three	Enter date: The expiration date of the previous coverage.
PRIOR CARRIER INFORMATION	General Aggregate Three	Enter limit: The liability aggregate limit amount.
PRIOR CARRIER INFORMATION	Each Occurrence Three	Enter limit: The liability each occurrence limit amount.
PRIOR CARRIER INFORMATION	Carrier Four	Enter text: The name of the previous insurer.
PRIOR CARRIER INFORMATION	Policy Number Four	Enter identifier: The policy number of the previous coverage.
PRIOR CARRIER INFORMATION	Policy Type-Claims Made (Checkbox) Four	Check the box (if applicable): Indicates the "coverage trigger" is on a claims-made basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Policy Type-Occurrence (Checkbox) Four	Check the box (if applicable): Indicates the "coverage trigger" is on an occurrence basis on a medical professional liability policy.
PRIOR CARRIER INFORMATION	Retro Date Four	Enter date: The retroactive date for the policy being described. This is the date for which an occurrence could "trigger" coverage under a Claims Made policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date Four	Enter date: The effective date of the prior policy.
PRIOR CARRIER INFORMATION	Eff-Exp Date Four	Enter date: The expiration date of the previous coverage.
PRIOR CARRIER INFORMATION	General Aggregate Four	Enter limit: The liability aggregate limit amount.
PRIOR CARRIER INFORMATION	Each Occurrence Four	Enter limit: The liability each occurrence limit amount.

Section Name	Field Name	Field and/or Section Description
GENERAL INFORMATION	Have You Ever Been Insured By Mutual Assurance Or Medical Assurance For Professional Liability?	Enter Y for a "Yes" response. Input N for "No" response. Indicates the answer to, "Have you ever been insured by mutual assurance or medical assurance for professional liability?".
GENERAL INFORMATION	Policy Number	Enter identifier: The policy number of the previous coverage.
GENERAL INFORMATION	Previous Employer	Enter text: The employer name (business name if self-employed). As used here, this is the previous employer name.
GENERAL INFORMATION	If professional liability coverage is provided through your employer, do you maintain a separate policy for professional liability?	Enter Y for a "Yes" response. Input N for "No" response. Indicates the response to the question, "Do you maintain a separate policy for professional liability?".
GENERAL INFORMATION	Have You Ever Been Diagnosed With Or Professionally Advised To Seek Treatment For Alcohol/Drug Abuse Or Addiction, Mental Illness Or Chronic Physical Illness?	Enter Y for a "Yes" response. Input N for "No" response. Indicates the response to the question, "Have you ever been diagnosed with or professionally advised to seek treatment for alcohol / drug abuse or addiction, mental illness or chronic physical illness?".
GENERAL INFORMATION	Have You Ever Been Diagnosed With Or Professionally Advised To Seek Treatment For Alcohol/Drug Abuse Or Addiction, Mental Illness Or Chronic Physical Illness? - Remarks	Enter text: A statement explaining if you have ever been diagnosed with or professionally advised to seek treatment for alcohol/drug abuse or addiction, mental illness or chronic physical illness.
GENERAL INFORMATION	Have any fee or professional relation complaints been registered against you with your professional association(s), hospital(s) or any state licensing authority?	Enter Y for a "Yes" response. Input N for "No" response. Indicates the answer to, "Have any fee or professional relation complaints been registered against you with your professional association(s), hospital(s) or any state licensing authority?".

Section Name	Field Name	Field and/or Section Description
GENERAL INFORMATION	Have any fee or professional relation complaints been registered against you with your professional association(s), hospital(s) or any state licensing authority? - Remarks	Enter text: An explanation of any fee or professional relation complaints that have been registered against you with your professional association(s), hospital(s) or any state licensing authority.
GENERAL INFORMATION	Have You Ever Been Charged With Or Convicted Of A Criminal Offense?	Enter Y for a "Yes" response. Input N for "No" response. Indicates the response to the question, "Have you ever been charged with or convicted of a criminal offense?".
GENERAL INFORMATION	Have You Ever Been Charged With Or Convicted Of A Criminal Offense? - Remarks	Enter text: A statement explaining if you have ever been charged or convicted with a criminal offense.
GENERAL INFORMATION	Has Your Professional Liability Insurance Ever Been Canceled, Suspended, Non-Renewed, Declined Or Issued Only On Special Terms?	Enter Y for a "Yes" response. Input N for "No" response. Indicates the response to the question, "Has your professional liability insurance ever been cancelled, suspended, non-renewed, declined or issued only on special terms?".
GENERAL INFORMATION	Has Your Professional Liability Insurance Ever Been Canceled, Suspended, Non-Renewed, Declined Or Issued Only On Special Terms? - Remarks	Enter text: A statement explaining if your professional liability insurance has ever been canceled, suspended, non-renewed, declined or issued only on special terms.
GENERAL INFORMATION	Are You A Subsidiary Of Another Entity Or Do You Have Any Subsidiary?	Enter Y for a "Yes" response. Input N for "No" response. Indicates the response to the question, "Are you a subsidiary of another entity or do you have any subsidiaries?".
GENERAL INFORMATION	Are You A Subsidiary Of Another Entity Or Do You Have Any Subsidiary? - Remarks	Enter text: A statement explaining if you are a subsidiary of another entity or have any subsidiary.
REMARKS		Enter text: The medical professional liability insurance application general remarks. ACORD 101, Additional Remarks Schedule, may be attached if more space is required.
IDENTIFICATION SECTION	Agency Customer ID	Enter identifier: The customer's identification number assigned by the producer (e.g. agency or brokerage).
REMARKS		Enter text: The medical professional liability insurance application general remarks. ACORD 101, Additional Remarks Schedule, may be attached if more space is required.

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SIGNATURE	Notice of Information Practices (Privacy) checkbox	Check the box (if applicable): Indicates that a copy of the Notice of Information Practices (ACORD 38 or state specific ACORD 38) has been given to the applicant. State specific 38s are available for applicants in AZ, DE, KS, MN, ND, NY, OR, VA, and WV. In addition, ACORD 38 contains CA and MA state specific language.
SIGNATURE	Applicant's Initials	Initial here: The named insured's initials.
SIGNATURE	Producers Signature	Sign here: Accommodates the signature of the authorized representative (e.g. producer, agent, broker, etc.) of the company(ies) listed on the document. This is required in most states.
SIGNATURE	Producer's Name	Enter text: The name of the authorized representative of the producer, agency and/or broker that signed the form.
SIGNATURE	State Producer License No	Enter identifier: The State License Number of the producer.
SIGNATURE	Applicant Signature	Sign here: Accommodates the signature of the applicant or named insured.
SIGNATURE	Date	Enter date: The date the form was signed by the named insured.
SIGNATURE	National Producer Number	Enter identifier: The National Producer Number (NPN) as defined in the National Insurance Producer Registry (NIPR). Note: The NPN is not the same as the producer state license number.
Edition	Date	The edition identifier of the form including the form number and edition (the date is typically formatted YYYY/MM).