Allied Healthcare Providers

PROASSURANCE®
Treated Fairly

Application

Medical Professional Liability

❑ Quote ❑ Issue

Please type or print. **EVERY ITEM MUST BE COMPLETED**. If not applicable, write N/A. If more space is needed, please use additional page.

Name of Applicant (Last, First, Middle): ______________________ Degree: ________

Social Security #: ______________________ Birth Date: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

Contact: ______________________

Mailing Address (Street or Box): ______________________ Suite: ______________

Mailing Address (City, State, ZIP): ______________________ County: ______________

Practice Address (if different): ______________________

Billing Address (if different): ______________________

1. Type of coverage desired: ❑ Claims-made ❑ Occurrence

2. Requested effective date: ________/________/________ (MO / DAY / YEAR)

3. Requested limits: ______________ (PER OCCURRENCE) **and** ______________ (AGGREGATE)

4. Occupation:

____

5. License number:

____

6. If an employee, give employer's name:

____

7. Provide name of supervising healthcare provider:

____

8. Will you be participating in a state-operated patients compensation fund?.. ❑ Yes ❑ No

State: ____________

9. Are you requesting Prior Acts Coverage?............ ❑ Yes ❑ No
If "yes," attach a copy of the current professional liability insurance policy, including Declarations and Endorsements. We cannot evaluate your applicaton without these documents.

Retroactive Date: ________/________/________ (MO / DAY / YEAR)

You are not eligible for Prior Acts Coverage unless you maintained continuous claims-made professional liability insurance with your own limits of liability during the entire requested Prior Acts Coverage period.

Note: Prior Acts Coverage is optional and subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting endorsement coverage from your current carrier unless you are specifically notified in writing by ProAssurance Casualty Company that your request for Prior Acts Coverage has been approved.

A. History

1. Current hospital staff appointments or privileges:

Hospital: ______________ Department: ______________

City: ______________ State: ______________

Appointment: ______________ Privileges: ______________

Hospital: ______________ Department: ______________

City: ______________ State: ______________

Appointment: ______________ Privileges: ______________

2. List healthcare training and education:

Location (school, hospital, etc.): ______________________

Date Completed: ______________________

Specialty: ______________________

Location (school, hospital, etc.): ______________________

Date Completed: ______________________

Specialty: ______________________

Please provide a copy of license or proof of additional training.

3. On a separate sheet, please give a complete explanation of all "yes" answers to the following questions.

a. Has your membership in any professional association or society ever been revoked or refused? .... ❑ Yes ❑ No

b. Have you ever voluntarily surrendered or had a state license to practice refused, suspended, or revoked? .... ❑ Yes ❑ No

c. Have you ever been treated for alcoholism, drug addiction, or mental illness? ❑ Yes ❑ No
If "yes," please provide details of rehabilitation program including dates of treatment.

d. Have you ever been convicted of a felony? ❑ Yes ❑ No

e. Have you ever suffered from or been treated for any chronic illness or physical defect? ❑ Yes ❑ No

f. Have you ever had any professional liability insurance refused, cancelled, or non-renewed? ❑ Yes ❑ No

g. Have any claims or suits ever been filed against you as a result of professional services? ❑ Yes ❑ No
If "yes," give details, amount paid, dates, etc. on Claim Information Sheet.

h. Were the claims identified in question A3g reported to a previous insurer? ❑ Yes ❑ No
If "yes," name the insurer(s) on the Claim Information Sheet.

i. Are you aware of any claims or suits against you that have not been reported to your previous insurer(s)? ❑ Yes ❑ No

j. Are you aware of any conduct, circumstances, occurrences, or incidents likely to give rise to a claim that have not been reported to your prior insurer(s)? ❑ Yes ❑ No
If you answer "yes" to question A3i or A3j, complete a separate Claim Information Sheet and provide a written narrative for each such claim or incident. For your protection, we urge you to report all applicable claims or incidents to your previous insurer(s).

k. Will you be carrying additional professional liability insurance with another company? ❑ Yes ❑ No
If "yes," show name of company, limits, expiration date, and services covered.

l. Have you ever had a grievance filed against you with a State Board of Regulation and Licensing, or have you been censured or received a private reprimand from any such organization or hospital? ❑ Yes ❑ No

B. Practice Information

1. Number of obstetrical deliveries per year: ______________________
2. Do you perform any experimental procedures (explain)? ❑ Yes ❑ No
3. Do you prescribe or administer medication, including anesthesia? ❑ Yes ❑ No
4. If you practice anesthesiology, do you use the end-tidal CO_2 analyzer and pulse oximeter? ❑ Yes ❑ No
5. Are you certified as an Advanced Practice Nurse Prescriber? ❑ Yes ❑ No
6. How many hours per week do you practice? ________________

   Hours per year? ____

PLEASE DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM THIS COMPANY.

THE ABOVE STATEMENTS ARE, TO THE BEST OF MY KNOWLEDGE, THE TRUTH, AND I HAVE NOT KNOWINGLY WITHHELD ANY INFORMATION IN COMPLETING THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE.

I hereby acknowledge that the foregoing information constitutes my application for insurance with ProAssurance Casualty Company (The Company), and that the information contained in the application will be relied upon by The Company in deciding whether or not to issue such insurance.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by The Company and I am notified by The Company of said acceptance.

Furthermore, I understand that, if requested, Prior Acts Coverage will not apply to liability arising out of any claims, suits, circumstances, conduct or incidents described in questions A3g through A3j of this application, unless such coverage is specifically granted in writing by ProAssurance Casualty Company. In addition, I understand that this Prior Acts Coverage does not apply to any claims or incidents that I have already reported to my previous insurers.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by The Company.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to The Company, and I expressly release and discharge The Company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by The Company to provide The Company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

Date Signed: ____

Signature of Applicant: ________________________________

Print Name: ____

Title: ____

THIS APPLICATION FORM DULY COMPLETED, TOGETHER WITH ANY SUPPLEMENTARY INFORMATION, MUST BE SIGNED IN INK BY THE APPLICANT. SIGNATURE OF THE FORM DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE.

Signature of Agent: ____________________________________

Name of Agency (type or print): __________________________

Telephone Number of Agency: ____________________________

Address of Agency: ____________________________________

How did you hear about ProAssurance Casualty Company?

❑ Insurance Agent
❑ Advertisement
   Which Publication? ______________________________
❑ ProAssurance Casualty Display Booth
   Which convention? ______________________________
❑ Colleague
❑ Website
❑ Direct Mail
❑ Other: Please explain ______________________________

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