Equity Partners Insurance Services, Inc	**Allied Medical - Healthcare Division**	**Allied Health Care Provider Professional Liability Application** **EMAIL:** submissions@epinsurance.com **WEBSITE:** www.epinsurance.com/alliedmedical-healthcare/

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

ALLIED HEALTH CARE PROVIDER PROFESSIONAL LIABILITY APPLICATION

PLEASE TYPE OR PRINT IN INK

(If more space is needed to answer any questions, use page 3 or a separate sheet.)

Name of Applicant:

Practice Name/Corporation:			
Employee ☐ Independent Contractor ☐			
Telephone Number: Area code ( )		Fax Number:	
Name of Physician Sponsor:			
What is your professional occupation?			
Requested Effective Date of Coverage:	Retroactive Date:	Social Security Number:	Date of Birth:

1) *Insurance History:* Provide details of coverage for the past five years.

Carrier	Limits		Effective Dates (month/yr)		Policy Type	
	Each Incident	Aggregate	From	To	Claims Made	Occurrence

2) Work History*:* Please provide a five (5) year history of employment. *(Use Supplemental Information page if additional space is needed.)*	Position Held	Dates Employed
Name Address		
Name Address		

3) Educational History	Name	Location	From To (month/year)		Completed (Y/N)	Degree/ Specialty
College						
Post-Graduate						
Other Training Specific to Professional Role						

4) Licensing	License #	Date Licensed	Expiration Date
State Board License: (Please list)			
Other States Licensed: (Please list)			
Prescriptive License:			
Other License (Describe)			

5) Current Certification	By Whom	Date Certified

6) How many Continuing Educational Units (CEU's) have you completed during the past year? _____ units

7) Privileges: (Please provide copies of all <u>current</u> delineation of privileges.)		
Hospital	City and State	Type/Category

8) Please complete the section that applies to your profession:

CERTIFIED REGISTERED NURSE ANESTHETIST

a) Are you AANA certified?	☐ Yes ☐ No
b) Are there other types of special anesthesia that you administer? ☐ Bier Block ☐ Monitored Anesthesia Care ☐ Regional Anesthesia ☐ Other	☐ Yes ☐ No
c) Is there a pre-anesthesia examination and conference with a patient to determine the type of anesthesia and to advise the patient what to expect?	☐ Yes ☐ No
d) Is there a post-anesthetic follow-up?	☐ Yes ☐ No
e) Have you established emergency procedures?	☐ Yes ☐ No
f) If you are providing out-patient/office anesthesia services, are your IV patents monitored with pulse oximetry?	☐ Yes ☐ No
g) Are you supervised by someone other than an on-site Anesthesiologist?	☐ Yes ☐ No

CERTIFIED NURSE MIDWIFE

Please attach a copy of your job description and your practice protocols for OB/GYN care.

PHYSICIAN ASSISTANT/SURGICAL ASSISTANT/NURSE PRACTITIONER

Please list below all invasive procedures that you perform in the office and/or in a hospital setting or attach a copy of your job description and/or your practice protocols:

If you answer yes to question 9-14, please provide details on the SUPPLEMENTAL INFORMATION page.

9) Has any licensing authority or hospital ever reprimanded you or ever denied, revoked, suspended, or restricted your medical license, narcotics license or practice privileges or put you on probation? ☐ Yes ☐ No

10) Has any licensing authority or hospital conducted (or are they currently conducting) an investigation relating to the restriction or limitation of your license or privileges of which you are aware? ☐ Yes ☐ No

11) Have you ever been diagnosed for any disease, or mental, physical, or emotional condition, including without limitation, chemical or alcohol dependency, or HIV/AIDS, which may affect your ability to render services as a health care provider? ☐ Yes ☐ No

12) Have you ever received treatment or medication, or, are you currently under treatment or medication, for any disease, or mental, physical or emotional condition, including without limitation, chemical or alcohol dependency, or HIV/AIDS, which may affect your ability to render services as a health care provider? ☐ Yes ☐ No

13) Has any similar insurance ever been declined, cancelled, non-renewed, or subjected to special conditions or limitations? ☐ Yes ☐ No

14) Do you make home health care visits? ☐ Yes ☐ No

If you answer yes to questions 15-16, please provide details on the SUPPLEMENTAL CLAIM INFORMATION page.

15) Have you ever been involved, directly or indirectly, or do you have knowledge of any: ☐ Yes ☐ No

a) Claim, potential claim, suit, or occurrence having potential for a claim, arising out of the rendering or failing to render professional services? ☐ Yes ☐ No

If yes, how many? ___ *(Please complete Supplemental Claim information page.)*

b) Claims or potential claims arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee of the corporation, partnership or Professional Association? ☐ Yes ☐ No

If yes, how many? ___ *(Please complete Supplemental Claim information page.)*

16) Have all such claims or occurrences been reported to your present carrier? ☐ Yes ☐ No

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In 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.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Equity Partners Insurance Services, Inc. and its respective Insurance Company[s] it is working with.

Signature of Applicant	Date

SUPPLEMENTAL INFORMATION

Please use this form to provide additional information or to answer any questions.

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same representations and conditions.

Signature of Applicant	**Date**

SUPPLEMENTAL CLAIM INFORMATION

PLEASE COMPLETE ONE FORM FOR EACH CLAIM. If space is insufficient to answer any question fully, please use reverse side or attach a separate sheet. Please do not leave any blanks.

1) Name of applicant:
2) Name of patient involved in the claim:
3) Date of incident or occurrence from which claim resulted or which is likely to result in a claim:
4) Date claim was made:
5) Allegations made against you:
6) Explain in detail the specifics of the occurrence which led or may lead to the claim:
7) Present status of claim: ☐ Active ☐ Dismissed ☐ Dropped ☐ Closed
If closed, please provide the amount of settlement or judgment: _____ Closed with no payment: ☐ Yes ☐ No
8) Name of insurance company involved:
9) Name(s) of other doctors and hospitals, if any, involved in the claim or suit:

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same representations and conditions.

Signature of Applicant	**Date**