



Nurses Professional Liability Application

Nurses, Nurse Practitioners, Nurse Anesthetists, PAs, Surgeon's Assistants, Paramedics, EMTs & Ambulance Services (Claims-Made)

INSTRUCTIONS: (1) Answer all questions; if a question does not apply, write "N/A". If an answer requires more detail, attach a separate sheet. (2) The application must be signed and dated by the owner, partner or officer (or the individual applicant). (3) Please read the statements at the end of this application carefully. Coverage applied for is on a claims-made basis.

PART I - ALL APPLICANTS MUST COMPLETE

1. Applicant information

a.(i) Full name of individual applicant: Professional degree:

(ii) Date of birth (mm/dd/yyyy): Place of birth:

b.(i) Principal business premises - street: County:

City: State: ZIP:

(ii) Other business locations:

(iii) Square feet of total office space (all locations):

(iv) Number of employees: full-time: Part-time: Total:

(v) Business phone: Home phone: Email:

c. If you practice other than as an employee OR an unincorporated solo practitioner:

(i) Formal business, corporate or partnership name:

(ii) Names of all partners or members of your professional association / corporation who provide professional services:

(iii) Please attach a copy of your letterhead.

d. Is the applicant a "Covered Entity" under the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule? ☐ Yes ☐ No

If yes: (i) Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No ☐ N/A

(ii) Name and title of the applicant's Privacy Officer:

The insurer's Business Associate Agreement will be provided with any quote, if applicable.

2. Applicant practice

a. Your practice:

- ☐ Solo practitioner (unincorporated) ☐ Solo practitioner (incorporated) ☐ Partnership ☐ Professional association
☐ Professional corporation (for profit) ☐ Professional corporation (non-profit) ☐ Employee ☐ Other

If employee, name of employer: If other, describe:

b. All states where you are licensed to practice (if none, attach an explanation):

c. Professional specialty (check one):

- ☐ Registered Nurse (RN) ☐ Licensed Practical / Vocational Nurse (LPN / LVN) ☐ Nurse Practitioner
☐ Nurse Anesthetist (CRNA) ☐ Physician's Assistant ☐ Surgeon's Assistant ☐ Paramedic
☐ Emergency Medical Technician (EMT) ☐ Ambulance Service ☐ Other (specify):

Other specialty (specify):

d. Approximate percentage of time spent in each work location (total 100%)

Work location	%	Work location	%	Work location	%
Administrative office		Nursing home		Patient's home	
Ambulance		Laboratory		Hospital ward *	
Classroom		Operating room		Professional office *	
Emergency dept. of hospital		Outpatient clinic		Other *	

* Specify hospital ward: Profession / office: Other:

e. Approximate division of your patients or clients (total 100%)

Patient type	%	Patient type	%	Patient type	%
Hemodialysis		Psychiatric		Bariatrics	
Holistic medicine		Drug addiction		Physical rehabilitation	
Surgical		Alcoholism		Disability evaluation	
Stress testing		Obstetrical		Research or experimental	
Communicable disease		Dental		Other (a) *	
Family planning		Pediatric		Other (b) *	

* Describe other (a): Other (b):

f. Number and type of your employees and / or volunteers (if none, write "None")

Type	Number	Type	Number	Type	Number
Emergency Medical Technicians		Nurse Practitioners		Physicians' Assistants	
Nurse Anesthetists		Paramedics		Surgeons' Assistants	

g. Are all of the above individuals licensed in accordance with applicable state and federal regulations? (If ☐ Yes ☐ No no, attach an explanation.)

h. Sources and amounts of actual and projected total revenue

Source	Amount this fiscal year (\$)	Amount next fiscal year (\$)
(i) Charitable contributions		
(ii) Government funding		
(iii) Fee for service		
(iv) Other		
Total gross revenue		

i. Patient encounters, last 12 months: and / or patient tests carried out:

j. Estimated patient encounters, next 12 months: and / or patient tests carried out:

Note: "patient encounters" refers to the number of visits, not the number of patients.

3. Applicant history (attach a detailed explanation for any "Yes" answer)

a. Have you or any of your employees ever:

(i) been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ☐ Yes ☐ No

(ii) been convicted for an act committed in violation of any law or ordinance, other than traffic offenses? ☐ Yes ☐ No

(iii) been treated for alcoholism or drug addiction? ☐ Yes ☐ No

(iv) had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or voluntarily surrendered same? ☐ Yes ☐ No

(v) had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

b. Prior professional liability insurance carried for each of the past four years (if none, write "None")

Insurance carrier	Policy number	Limits of liability	Deductible (if any)	Premium	Inception (mm/dd/yyyy)	Expiration (mm/dd/yyyy)	Claims-made? (Y/N)

c. If prior coverage was claims-made, retroactive date (mm/dd/yyyy):

d. Does the applicant currently participate, or plan to participate, in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? ☐ Yes ☐ No

4. Personnel**a. Number and type of independent contractors who provide professional services on your behalf (if none, write "None")**

Type	Number	Type	Number	Type	Number
Emergency Medical Technicians		Nurse Practitioners		Physicians' Assistants	
Nurse Anesthetists		Paramedics		Surgeons' Assistants	

b. Do you supervise any individuals who are not your own employees? ☐ Yes ☐ No

If yes, detailed explanation of responsibilities and relationship to the entity which employs these individuals:

c. Number of individuals you supervise, by profession

Type of profession	Number	Type of profession	Number	Type of profession	Number
Emergency Medical Technicians		Nurses, Licensed Practical		Paramedics	
Laboratory Technicians		Nurse Practitioners		Physicians' Assistants	
Nurse Anesthetists		Nurses, Registered		Surgeons' Assistants	

5. Applicant procedures

a. Do you render professional services directly to patients? ☐ Yes ☐ No

If yes, describe these services and indicate whether you are supervised and by whom

Detailed description of professional services	% of time supervised	Title of supervisor

b. Do you render professional services that do not involve contact with a patient? ☐ Yes ☐ No

If yes, please describe these services in detail:

c. Do you administer any anesthesia? ☐ Yes ☐ No

If yes, please explain and indicate whether you are supervised and by whom:

d.(i) Do you perform or assist in any surgical procedure(s)? ☐ Yes ☐ No

(ii) If yes, list ALL surgical procedures performed (including minor surgery):

If yes: (iii) Is anesthesia (other than topical or local infiltration) administered by yourself or others? (attach details) ☐ Yes ☐ No ☐ N/A

If yes: (iv) Do you perform or assist in surgery in a professional office or similar non-hospital facility? (attach details) ☐ Yes ☐ No ☐ N/A

- e.(i) Do you perform radiation therapy? ☐ Yes ☐ No
- (ii) Do you perform psychiatric shock therapy? ☐ Yes ☐ No
- f. Do you prescribe or dispense any drugs without the countersignature of a physician? ☐ Yes ☐ No

If yes, please provide a detailed explanation:

6. Applicant affiliations (if yes to b - h, attach an explanation, including details of your responsibilities)

- a. Are you associated with, or do you work for, a physician or surgeon? ☐ Yes ☐ No

If yes, name and specialty of the physician:

- b. Do you own or operate any business other than that shown in question 1 above? ☐ Yes ☐ No
- c. Are you employed by an individual other than that shown in question 1 above? ☐ Yes ☐ No
- d. Are you under contract to any individual or entity other than that shown in question 1 above? (If the contract contains a hold-harmless agreement, attach a copy.) ☐ Yes ☐ No
- e. Are you employed by any governmental entity? ☐ Yes ☐ No
- f. Are you under contract to any governmental entity? ☐ Yes ☐ No
- g. Do you advertise your professional services in any manner (other than a simple directory listing)? If yes, attach copies of ALL advertisements. ☐ Yes ☐ No
- h. Are you associated with any agency or organization that advertises for, or solicits, patients? If yes, attach details and ALL relevant advertisements. ☐ Yes ☐ No

7. Claims

- a. Has any claim or suit been brought against you and / or any of your employees? (If yes, complete a Supplemental Claim Information sheet for each.) ☐ Yes ☐ No
- b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? ☐ Yes ☐ No

If yes, please provide details:

8. Professional societies

- a. Membership in professional societies or associations:

PART II - INDIVIDUAL APPLICANTS ONLY

1. Citizenship: are you a U.S. citizen? ☐ Yes ☐ No

If no, your status:

Date of entry into the U.S. (mm/dd/yyyy):

2. Education - describe your professional training

Institution (name and address)	From	To	Degree or certification attained

3. Experience - where have you practiced your profession during the last ten years?

	From	To	Location	Practice activity
a.				
b.				
c.				

- d. Have you ever failed any professional licensing or specialty organization examination? (If yes, attach details, including dates and location.) ☐ Yes ☐ No

PART III - AMBULANCE SERVICES / GROUPS OF PARAMEDICS OR EMTS

Answer only if a quotation is requested to cover a group of paramedics or emergency medical technicians and / or the employer. To be completed by the administrator or business manager, who must also sign this application.

1. Service boundary: radius of operations of the ambulance service:

2. Annual numbers

	Last 12 months	Estimated next 12 months
a. Patient encounters (patients transported)		
b. Calls for emergencies		
c. Non-accident transports to / from a hospital or institution		

NOTICE, WARRANTY, FRAUD WARNING & SIGNATURE

NOTICE TO APPLICANT: The coverage applied for is **SOLELY AS STATED IN THE POLICY**, which provides coverage on a "CLAIMS-MADE" basis for **ONLY 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.

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 the insurer and / or its affiliates.

Signing this application does not bind the applicant or the insurer to complete the insurance, but one copy of this application will be attached to the policy, if issued.

FRAUD WARNING: 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, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject the person to criminal and civil penalties, including fines, imprisonment and denial of insurance benefits. State-specific fraud notices (including AL, AR, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, WA and WV) apply and will be provided by the insurer where required.

☐ I Accept

By checking "I Accept", the applicant consents and agrees that using a keypad, mouse or other device to check "I Accept" constitutes the applicant's signature, acceptance and agreement as if signed by the applicant in writing, with the same force and effect as a handwritten signature. The applicant also agrees that the lack of a certification authority or other third-party verification will not affect the validity or enforceability of the signature or any resulting contract.

Signature (applicant): Date (mm/dd/yyyy):

Name of applicant: Title (officer, partner, etc.):

How did you hear about us? (optional):

Please make sure the following items are included (as applicable):

- ☐ Copy of your letterhead (Part I, 1c)
- ☐ Explanation if not licensed in any state (2b)
- ☐ Explanation of any unlicensed staff (2g)
- ☐ Detailed explanation of any "Yes" answer in Applicant History (3a)
- ☐ Explanation of supervision of non-employees (4b)
- ☐ Anesthesia / office surgery explanations (5d)
- ☐ Explanations for affiliations questions 6b - 6h, contracts with hold-harmless agreements and copies of ALL advertisements
- ☐ A Supplemental Claim Information sheet for each claim or suit (7a)
- ☐ Details of any potential claim or circumstance (7b)
- ☐ Explanation of any failed licensing / specialty examination (Part II, 3d)
- ☐ Declarations page of your current professional liability policy

SUPPLEMENTAL CLAIM INFORMATION - CLAIM 1

Complete one sheet for each claim or suit (copy this page or attach a separate sheet for more). If space is not enough to answer fully, attach a separate sheet. Answer all questions completely.

1. Name of applicant:

2. Name of patient / claimant: Age: Sex:

3. Allegation:

4. Date(s) of treatment for allegation:

Location:

5. Date claim / suit reported: Name of insurer:

6. Additional defendants:

7. Current disposition: ☐ Open ☐ Closed

Open - amount of reserve \$ Closed - amount of settlement or judgment \$

Amount paid on applicant's behalf \$

If no payment, was the claim / suit withdrawn? ☐ Yes ☐ No ☐ N/A

8. Date claim closed or suit withdrawn:

9. Narrative description of the case, including the nature of the treatment, your involvement, etc.:

I understand the information submitted here becomes part of my Professional Liability Application as submitted.

Applicant's signature: Date (mm/dd/yyyy):