Professional Solutions
INSURANCE COMPANY
A Member of NCMIC Group, Inc.

EMPLOYED ANCILLARY PROVIDERS APPLICATION

FOR CLAIMS-MADE PROFESSIONAL LIABILITY COVERAGE

Please answer all questions. If your answer to any question is "NONE" or "NOT APPLICABLE", please indicate. If you need more room attach a separate signed and dated sheet.

1. GENERAL INFORMATION

Name: ____
LAST FIRST MIDDLE INITIAL

Designation (s): ____

Social Security No: ________-______-________ Date of Birth: ______/______/______ Gender: ☐ M ☐ F

Name of Employer: ____

Practice Address: ____
STREET CITY STATE COUNTY ZIP

Home Address: ____
STREET CITY STATE ZIP

Daytime Phone No: (_______) ____________________ Fax No.: (_______) ______________________

E-Mail Address: ____
(For NCMIC use only. We will never sell or rent your email address.)

2. COVERAGE INFORMATION

Requested Effective Date: ____/____/____ **Date Employed at Current Practice:** ____/____/____

Policy Limits of Employer: ☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $500,000/$1,000,000 ☐ $1,000,000/$3,000,000

List prior malpractice carriers (if none, state "none"):

Effective Date	Expiration Date	Insurer	Claims-Made or Occurrence	Limits of Liability
____/____/____	____/____/____	_____________	______________________	________________
____/____/____	____/____/____	_____________	______________________	________________

If prior policy was claims-made, have you secured tail coverage from you prior carrier? ☐ Yes ☐ No
If "no", indicate requested retroactive date on this coverage: ____/____/____

Please attach declaration pages showing proof of insurance from retroactive date to present.

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3. PRACTICE INFORMATION

Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage? .... ☐ Yes ☐No

If "Yes," please list name of employer and insurance carrier:

Employer: ____

Insurance Carrier: ____

Policy number: ____

Are you required by the state in which you practice to be (please check which applies)
☐ licensed
☐ certified
☐ registered

If "Yes," please provide the following information:

License, Certification or Registration Number Issued	State Issued	% of Practice in each State	Active Status
______________________	__________	___________	☐ Yes ☐ No
______________________	__________	___________	☐ Yes ☐ No
______________________	__________	___________	☐ Yes ☐ No

Please indicate your specific occupation:

☐ Physicians Assistant
☐ Surgical Assistant
☐ H/L Profusionist
☐ O.R. Technician
☐ Other __________________________
☐ Paramedical
☐ Scrub Nurse
☐ Nurse Midwife (No Delivery)
☐ Nurse Midwife (Delivery)
☐ Nurse Anesthetist
☐ Nurse Practitioner
☐ Psychologist

Please list the professional school from which you graduated: ________________________________

Date of graduation (mo./yr.): ____/____

Board Certification: A) Are you Board Eligible? .... ☐ Yes ☐ No
B) Are you Board Certified? .... ☐ Yes ☐ No
C) If "Yes" to A or B, please list Board: ____________________________________

Are you currently enrolled in a Patient Compensation Fund (PCF)? .... ☐ Yes ☐ No
If "yes," please list state(s): ____

Are you licensed to prescribe drugs? .... ☐ Yes ☐ No

Do you perform surgical procedures?.. ☐ Yes ☐ No

Please provide a thorough description of your duties for which you are requesting coverage:

____

____

____

____

Hours worked per week for employer: ___________________________

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4. PRIOR EXPERIENCE & COVERAGE

Explain any “yes” answers to the following questions on a separate sheet and provide any applicable board transcripts or other pertinent information.

A. **Are you now, or have you ever, practiced without professional liability insurance?** .... ☐ Yes ☐ No

B. **Has any hospital ever denied, restricted, suspended or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation ever been invoked?** .... ☐ Yes ☐ No

C. **Have you ever had professional liability insurance issued with reduced limits or a deductible, issued with a special surcharge or another special term?** .... ☐ Yes ☐ No

D. **Has your professional liability insurance ever been denied, cancelled or non-renewed?** .... ☐ Yes ☐ No

(Note: Missouri applicants are not required to answer this question.)

E. **Has your narcotics or medical license or certification ever been suspended, restricted, revoked or voluntarily surrendered, or has probation been invoked?** .... ☐ Yes ☐ No

F. **Have you been asked to participate in or have you volunteered to participate in an impaired provider program?** .... ☐ Yes ☐ No

If “yes,” please attach a copy of your recovery plan document.

G. **Have you ever been denied a professional license or been denied certification by a specialty board?** .... ☐ Yes ☐ No

H. **Have you ever been the subject of disciplinary proceedings; or reprimanded by a governmental agency, or convicted or currently under investigation for a crime other than a traffic offense?** .... ☐ Yes ☐ No

I. **Have any claims or suits been made or brought against you in the past 10 years?** .... ☐ Yes ☐ No

If “yes,” please complete the attached “Claims Information Form” for each claim or suit.

J. **Do you have knowledge of any claims that might be made against you, or activities that might give rise to a claim?** .... ☐ Yes ☐ No

If “yes,” please include details on the attached “Claims Information Form” for each claim or suit.

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5. PLEASE READ, SIGN AND DATE

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Insurance coverage becomes effective upon approval of the application and issuance of the policy. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT. Acceptance of the premium does not constitute approval of the application.

The foregoing answers are complete and correct to the best of my knowledge and belief.

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection.

I understand that my Professional Liability coverage will be written on a “Claims-Made” form and acknowledge that this coverage will only respond to claims that are reported during the term of this policy. I also acknowledge that my “Claims-Made” coverage will not provide insurance coverage for claims that occurred prior to the “Retroactive Date” of my policy.

I understand that, should I decide to cancel this “Claims-Made policy, and I desire to provide insurance protection for any claims that may have occurred during the term of the “Claims-Made” policy, but were not reported in writing to the insurance company before the date of the policy termination, I will be able to purchase tail coverage within sixty (60) days of the cancellation date.

X ______________________________ **X**____________

SIGNATURE **DATE**

Underwritten by:

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CLAIM INFORMATION FORM

1. Name of Applicant: ______________________________
2. Patient's Name: ______________________________
3. Date of Incident from which claim or suit resulted or is likely to result:: ______________________________
4. Date claim was made against you: ______________________________
5. Allegations made against you: ______________________________
   ____
   ____
   ____
6. Explain, in detail, the specifics of the incident which led to the claim: ______________________________
   ____
   ____
   ____
7. Present status or disposition of claim including amount reserved or amount of settlement or judgment, if any: State, County and Court claim filed in: ______________________________
   ____
8. What insurance company was involved?
   ____
   ____
9. Name of doctors, hospitals, institutions or any other professionals, if any, involved in the claims or suit:
   ____
   ____
   ____
   ____

X ______________________________ **X** ______________
SIGNATURE **DATE**

Please photocopy as necessary for each claim or incident.

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