

RENEWAL REQUEST FOR EMPLOYED ANCILLARY PROVIDERS

Please answer all questions. If your answer to any question is "NONE" or "NOT APPLICABLE," please state N/A.

SECTION A - GENERAL INFORMATION

Name: _____
LAST
FIRST
MIDDLE INITIAL

Name of Employer: _____ Expiring Policy No.: _____

Address: _____ County: _____

Renewal Effective Date: _____ to: _____

Please check your professional designation:

- | | |
|---|--|
| <input type="checkbox"/> Physician Assistant (PA) | <input type="checkbox"/> Nurse Practitioner (NP) |
| <input type="checkbox"/> Nurse Anesthetist (CRNA) | <input type="checkbox"/> Surgical Assistant |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Other _____ |

SECTION B – LIMIT OF LIABILITY - please check one option

(Your limit of liability must be equal to that of your employer's)

- Separate Limits
- Shared Limits with your employer's corporation (this option is not available if there is no corporation)

SECTION C - PRACTICE INFORMATION

1. Are you required by the state(s) in which you practice to be (please check all that apply):
- Licensed
 - Certified
 - Registered

✓ If yes, please provide the following information:

License/Certification/ Registration #	State	% of Practice	Active Status	
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
_____	_____	_____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

2. Are you licensed to prescribe drugs?..... YES NO

3. Do you perform surgical procedures?..... YES NO

4. Please provide a thorough description of the duties for which you are requesting coverage:

5. Are you currently enrolled in a State Patient Compensation Fund?..... YES NO

✓ If yes, please list the state(s): _____

6. Do you practice in more than one location? YES NO
✓ If yes, please list each additional location on a separate sheet of paper and indicate the % of practice at each location.
7. Total number of hours you work on average per week for the employer noted above: _____
 If you work less than 20 hours per week on average, how long have you practiced at these reduced hours? _____
8. Have you completed a loss prevention program in the past year? YES NO
✓ If yes, please list program and date(s) attended:
9. Have you participated in any CME during the past year?..... YES NO
10. Have there been any changes in your practice, specialty or Board Certification in the past year? YES NO
✓ If yes, please provide full details on a separate sheet of paper.
11. Do you utilize an Electronic Medical Record (EMR) system?..... YES NO
 a. If yes, for how long? _____
 b. If you are in a group practice, do all members of the group utilize the EMR system? YES NO
 c. If no, please explain: _____

SECTION D – OTHER AFFILIATIONS

1. 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 provide the following information and attach a copy of your Declarations page from the policy that provides coverage:
- a. Your employer: _____
 b. Insurance Carrier: _____
 c. Policy No.: _____
 d. Type of activities covered: _____

SECTION E - TREATMENT INFORMATION

1. If you practice any of the following forms of “Alternative Medicine” do you hold a separate license or are you certified by your licensing state to practice Alternative Medicine? If yes, please provide a copy.

	<input type="checkbox"/> YES <input type="checkbox"/> NO	% of Practice:
Acupuncture/Oriental Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ %
Ayurvedic Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ %
Chiropractic Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ %
Holistic Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ %
Homeopathic Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ %
Naturopathic Medicine	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ %

- a. If you answered “Yes” to any of the above, are you a member of:**
- AANP YES NO
 ACAM YES NO
Diplomat Candidate YES NO
Diplomat YES NO
Follower of Protocol YES NO

SECTION F – Please explain any “Yes” answers to the following questions on a separate sheet of paper and provide any applicable board transcripts or other pertinent information.

1. In the past year, has any hospital denied, restricted, suspended or revoked your privileges; have you voluntarily surrendered your privileges; or has probation been invoked? YES NO
2. In the past year, has your narcotic or medical license been suspended, placed on probation, restricted, revoked or voluntarily surrendered? YES NO
3. In the past year, were you 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.
4. In the past year, were you the subject of disciplinary proceedings; reprimanded by a governmental agency; convicted of a crime, or are you currently under investigation for a crime other than a traffic offense? YES NO
5. In the past year, have any claims or suits been made or brought against you? YES NO
✓ If “Yes,” please complete a “Claim Information Form” for each claim or suit.
6. 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 complete a “Claim Information Form” for each incident.
7. In the past year, has any claim or suit for alleged sexual misconduct been brought against you? YES NO

SECTION G - PLEASE READ, SIGN AND DATE

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and that I have not willfully concealed or misrepresented any material fact or circumstance concerning this insurance of the subject thereof. I further understand that the above statements are material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

GENERAL FRAUD WARNING - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

X _____
DOCTOR’S SIGNATURE

X _____
DATE

1. Name of Applicant: _____
LAST FIRST MIDDLE INITIAL

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: _____

8. State, County and Court claim filed in: _____

9. What insurance company was involved? _____

10. Names of doctors, hospitals, institutions or any other professionals, if any, involved in the claims or suits: _____

X _____
DOCTOR'S SIGNATURE

X _____
DATE

Please photocopy this form as necessary for each claim or incident.