



**Medical Professional Liability Insurance Application Nurse Practitioners**

I warrant that all information in this application is true and complete and understand that this application form shall be the basis for endorsing my employer's/supervisor's Medical Professional Liability contract with American Physicians Insurance Company.

**INSTRUCTIONS:**

1. Answer all questions. If a question is not applicable, state NOT APPLICABLE.
2. If space is insufficient to answer any questions fully, attach separate sheet.
3. Application must be signed and dated.
4. If the answer to any question is none, state NONE.
5. Please submit a written protocol and (if seeking vicarious coverage) proof of individual coverage. Application will not be considered complete without these items.

**PLEASE TYPE OR PRINT IN BLACK INK AND ANSWER ALL QUESTIONS IN DETAIL. COVERAGE WILL NOT BE CONSIDERED UNTIL APPLICATION IS COMPLETED AND SIGNED.**

**PERSONAL INFORMATION**

Full Name \_\_\_\_\_ Sex:  Male  Female

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Place of Birth \_\_\_\_\_ Are you a U.S. Citizen?  Yes  No

Home Address \_\_\_\_\_ Street & Number \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_

**CONTACT INFORMATION**

Business Address \_\_\_\_\_ Street & Number \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Fax \_\_\_\_\_

Business Website \_\_\_\_\_

Office Contact Name \_\_\_\_\_ Office Contact E-mail Address \_\_\_\_\_

Office Contact Title \_\_\_\_\_

Office Contact Phone \_\_\_\_\_ Office Contact Fax \_\_\_\_\_

Administrator Name \_\_\_\_\_ Administrator E-mail address \_\_\_\_\_

Administrator Phone \_\_\_\_\_ Administrator Fax \_\_\_\_\_



## CLAIMS HISTORY

**PLEASE NOTE THAT A COMPLETE CLAIM/ SUIT ADDENDUM IN THE APPLICANT'S OWN WORDS FOR EACH INCIDENT NOTED BELOW MUST BE ATTACHED FOR THE APPLICATION TO BE PROCESSED**

**LIST ALL CLAIM(S) INFORMATION FROM JANUARY 1, 2003 TO THE PRESENT**

- All claims listed on your application must have been reported to your prior insurer(s).
- All claims not listed on your application must have been reported to your prior insurer(s).
- A claim, potential claim, incident, or lawsuit reported to a previous insurer is not covered by American Physicians Insurance Company . Furthermore, under no circumstances or event will any coverage apply to any claim, potential claim, incident, or lawsuit which is known or which may arise out of any incident which is known by any named insured, physician extender, or ancillary personnel as of the effective date of this policy. It is your responsibility to report all claims, potential claims, incidents or lawsuits, which are known or which may arise out of an incident which is known, to your previous insurer(s).

1. Are you now or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising from the rendering of, or failure to render professional services?

Yes  No

If yes, how many? \_\_\_\_\_ A number must be specified along with the corresponding narrative(s)

2. If you are a member of a Partnership, Professional Corporation or Professional Association, do you have knowledge of any claims or potential claims arising from the rendering of, or failure 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? \_\_\_\_\_ Have these been reported to your previous insurer(s)?  Yes  No

**Claims listed as part of this application are not considered claims reported to us.**

## CURRENT PROFESSIONAL LIABILITY INFORMATION

**Please complete the following indicating your Professional Liability carrier(s) since your requested retroactive date. PLEASE ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR CURRENT POLICY OR A CERTIFICATE OF INSURANCE ISSUED FROM YOUR CURRENT CARRIER REFERENCING YOUR CURRENT POLICY.**

Professional Liability Carrier	Limits of Liability	Dates Insured	Type
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)
Carrier Policy #		From: To: Retroactive Date:	Occurrence / Claims Made (Circle one)

## TYPE OF PRACTICE

- |   |  |   |
|---|--|---|
| I am an<br><input type="checkbox"/> Employee<br><input type="checkbox"/> Independent Contractor<br><input type="checkbox"/> Self-Employed<br><input type="checkbox"/> Other _____ | Of a<br><input type="checkbox"/> Anesthesiologist<br><input type="checkbox"/> Dentist or Oral Surgeon<br><input type="checkbox"/> Hospital<br><input type="checkbox"/> Other _____ | <input type="checkbox"/> PA<br><input type="checkbox"/> Partnership<br><input type="checkbox"/> Corporation |
|---|--|---|

Name of Practice	Address	City	State	Zip Code
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Date(s) you begin working for the practice listed above? \_\_\_\_\_

1. In what specialty(ies) do you practice? \_\_\_\_\_

2. Do you have on-site supervision for all procedures?  Yes  No

By whom? \_\_\_\_\_

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

If yes, please describe in detail the services and indicate whether you are supervised and by whom:

Detailed Description of Professional Services	% of Time Supervised	Qualifications of Supervisor
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. State approximate division of your patients and/or clients:

Hemodialysis _____%	Psychiatric _____%	Physical Rehabilitation _____%
Holistic Medicine _____%	Drug Addicts _____%	Disability Evaluation _____%
Surgical _____%	Alcoholics _____%	Stress Testing _____%
Obstetrical _____%	Communicable _____%	Family Planning _____%
Pediatrics _____%	Bariatrics _____%	
Other (please describe and give percent) _____%		

5. Indicate percent of time spent in the following work locations:

\_\_\_\_\_% Administrative Office  
\_\_\_\_\_% Emergency Dept. of Hospital  
\_\_\_\_\_% Laboratory  
\_\_\_\_\_% Nursing Home  
\_\_\_\_\_% Outpatient Clinic

\_\_\_\_\_% Patient's Home  
\_\_\_\_\_% Hospital Ward (specify) \_\_\_\_\_  
\_\_\_\_\_% Operating Room  
\_\_\_\_\_% Professional Office (specify profession) \_\_\_\_\_  
\_\_\_\_\_% Other (specify) \_\_\_\_\_

6. Do you prescribe or dispense any drugs without the countersignature of a physician?  Yes  No

If yes, please explain \_\_\_\_\_

7. Do you perform unassisted surgical procedures?  Yes  No

If yes, please explain \_\_\_\_\_

8. Do you carry out treatment plans without the direct supervision of your physician employer?  Yes  No

If yes, please explain \_\_\_\_\_

9. Do you see patients or make hospital rounds without the direct supervision of physician employer?  Yes  No

If yes, please explain \_\_\_\_\_

10. Do you perform Norplant procedures?  Yes  No

Insertion  Removal

Please describe your Norplant experience and/or training \_\_\_\_\_

11. Do you take calls for physicians other than your employer?  Yes  No

If yes, please explain \_\_\_\_\_

12. Do you work in a location other than where your employer/supervisor provides services?  Yes  No

If yes, please explain \_\_\_\_\_

14. Do you have prescriptive authority for Controlled Substances?  Yes  No

If yes, DEA# \_\_\_\_\_ Expiration date \_\_\_\_\_

Delegating Physician \_\_\_\_\_

15. Do you perform any invasive procedures without the direct supervision of your physician employer?

If yes, please explain \_\_\_\_\_

11. Do you perform intra-articular joint injections?  Yes  No

If yes, please explain training \_\_\_\_\_

**GENERAL INFORMATION**

- 1. Have any of the following, now or ever, been under review, under investigation, revoked, denied, suspended, voluntarily surrendered, or in any way limited?
  - Your permit to prescribe or dispense drugs  Yes  No
  - Your nursing certification and/or license  Yes  No
  - Your hospital privileges  Yes  No
  - Your Medicare/Medicaid accreditation, certification, or Medicare/Medicaid license  Yes  No
- 2. Have you ever been or are you now under review by any entity, organization or peer review board?  Yes  No
- 3. Have you even been under review or investigated by any State Medical Board?  Yes  No
- 4. Have you ever been or are you now being investigated, charged with, or convicted of a felony or state jail felony?  Yes  No
- 5. Have you ever been, or are you now, being treated for:
  - Chronic illness or physical disability which may limit your abilities to practice  Yes  No
  - Alcoholism or narcotic addiction  Yes  No
  - Mental illness  Yes  No

6. Have you ever been advised that your medical professional liability insurance would or might be declined, non-renewed, or accepted on special terms?  
 Yes  No

7. Have you ever been or are you now an employee of or do any contract work for any federal, state, local or government agency?  Yes  No

If "yes", please give details, including whether professional liability insurance is provided for you.

\_\_\_\_\_

8. Are you currently an employee of or do contract work for any other entities, including other physicians, emergency room (s), or minor emergency medical organizations for which you are paid?  Yes  No

If yes, please list \_\_\_\_\_

Do you require coverage for this practice?  Yes  No

9. If you answered "yes" to any question in the General Information section, please explain in detail below or attach an explanation to this application. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with the company, American Physicians Insurance Company. All statements are my own representations and are true, to the best of my knowledge. I have not knowingly withheld any information that is calculated to influence the judgment of the Company in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance on the truth of my representations. I understand that no insurance will be afforded unless and until this application is approved by the company and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by the company. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, and individuals. I expressly release and discharge the aforesaid entities, their agents, employees and/ or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as the evaluation of information so received from whatever source.

I understand that, if I am insured by the company, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with the company and any party furnishing information pursuant to this authorization is entitled to rely on the representation of the company that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to the company.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Date

**PLEASE COMPLETE ENTIRE APPLICATION, AND SUBMIT WITH COPY OF PROTOCOLS AND COPY OF INDIVIDUAL CERTIFICATE OF INSURANCE.**

**INCOMPLETE APPLICATIONS WILL BE RETURNED**

**NOTE: Signature of this form does not bind the Applicant or the Company and no insurance coverage will be considered to be in effect until the applicant has received a confirmation in writing, duly executed by the company.**



### Claim/Suit Information Addendum

COMPLETE ONE CLAIM/SUIT INFORMATION ADDENDUM IN THE APPLICANT'S OWN WORDS FOR EACH INCIDENT, CLAIM OR SUIT.  
PLEASE PRINT ALL INFORMATION.

Doctor's Name \_\_\_\_\_

1. Name, age, and sex of patient/claimant \_\_\_\_\_

2. Date(s) of treatment and/or surgery which led to the allegations against you (month/year) \_\_\_\_\_

3. Nature of the allegations in the claim or suit, or description of medical incident \_\_\_\_\_  
\_\_\_\_\_

4. Specify incident or claim report date(s) \_\_\_\_\_

5. Specify if a suit was ever filed:  Yes  No If yes, provide (month/year) \_\_\_\_\_

6. Name of the other doctor(s) and hospital(s), if any, involved in claim or suit \_\_\_\_\_  
\_\_\_\_\_

7. Disposition or current status of incident, claim or suit

- Incident only.
- OPEN CLAIM-Indicate case value established by insurance company, if known \$ \_\_\_\_\_
- CLOSED CLAIM-Was payment made?  Yes  No If yes, when \_\_\_\_/\_\_\_\_/\_\_\_\_
- If no, was claim or suit withdrawn?  Yes  No
- If payment was made, indicate amount of  settlement \$ \_\_\_\_\_  award \$ \_\_\_\_\_
- Amount paid on your behalf: \_\_\_\_\_

8. Name of insurance company defending you \_\_\_\_\_  
Policy Number \_\_\_\_\_

9. Narrative description of the medical facts (must include, but is not limited to, the type of treatment and/or surgery; and your involvement, i.e., consultant, assistant in surgery, E.R. physician, primary surgeon, resident, etc.).  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_