



Allied Health Professional Liability Insurance Application Form

With your fully completed, signed and dated application, you **must** submit the following information:

1. Current insurance policy declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Articles of Incorporation, if applicable.
5. Loss runs from all prior insurance companies or explanation as to why they are not available.
6. Copy of curriculum vitae.

***Note:** Submission of a completed application confers no obligation upon the Company to bind coverage.*

ProAssurance Casualty Company
P.O. Box 150
Okemos, MI 48805-0150
800.282.6242 • 608.828.1100 (Fax)

B. Are you a member of any professional organization? Yes No

If yes, please give details. _____

5. Professional Liability Insurance History

Name of Company (Current)	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
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A. Have you ever applied to a ProAssurance company for insurance before? Yes No

B. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage? Yes No

If yes, requested retroactive date: _____

Important: If you are not applying for prior acts coverage and are not purchasing a reporting endorsement from your current carrier, please explain why on a separate sheet.

C. Have you changed your field or scope of practice or modified your specialty during the past three years? Yes No

If yes, please explain: _____

D. Have you changed the address of your practice during the past three years? Yes No

If yes, list prior addresses: _____

E. Has an insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes No

F. Have you ever:
i. Been charged with, pled guilty to, or convicted of a criminal offense? Yes No

ii. Been treated for (or recommended for treatment of) alcoholism, sexual addiction, anger management or drug addiction? Yes No

iii. Undergone or been recommended to undergo psychiatric treatment? Yes No

iv. Had a complaint filed against you with any hospital, professional society or regulatory board? Yes No

v. Had any professional license/permit or narcotics license investigated, suspended, revoked, restricted or placed under probation? Yes No

vi. Failed a licensing, specialty or board certification exam? Yes No

If you answer yes to question(s) 5C, 5D, 5E, or any part of 5F, please provide complete details on a separate sheet of paper.

G. Have any judgments ever been rendered against you or any out-of-court settlements in excess of \$500 been made on your behalf from an incident alleging professional errors or omissions? Yes No

If available, please enclose a copy of complaint.

H. Has any action been filed against you or have you been notified that any action, regardless of dollar amount, will be filed against you alleging professional errors or omissions? Yes No

If available, please enclose a copy of complaint.

If you answer yes, to question(s) 5G, or 5H, please complete the attached Supplementary Claims Information Form.

6. Rating Information

A. Profession:

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Certified Nurse Practitioner |
| <input type="checkbox"/> Surgical Assistant | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Certified Registered Nurse Anesthetist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Cytotechnologist | <input type="checkbox"/> Emergency Medical Tech |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Radiology Tech | <input type="checkbox"/> Radiation Tech |
| <input type="checkbox"/> Occupational Tech | <input type="checkbox"/> Respiratory Tech | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> RN/LPN | <input type="checkbox"/> Phlebotomist | <input type="checkbox"/> Certified Nurse Midwife |
| <input type="checkbox"/> Other (explain): _____ | | |

B. Do you moonlight (work outside control of the above employer)? Yes No
 If yes, where?

C. Will you be scheduled to work at a separate location from your supervising physician? Yes No
 If yes, please give details on a separate sheet.

D. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? Yes No

E. Do you elicit, evaluate and record the health, psychosocial and developmental history of the patient? Yes No

F. Do you order or perform diagnostic tests? Yes No

G. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referrals and consultations when needed? Yes No

H. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes No

I. Do you perform a physical examination? Yes No
 If yes, briefly describe techniques and instruments used.

J. Do you conduct informed consent discussions? Yes No

K. Do you assist in surgery? Yes No

L. Do you administer anesthesia? Yes No

M. Do you perform normal deliveries? Yes No

N. Describe any other procedures, treatments, or duties you perform.

O. If applicable, describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice.

P. Are you employed by, or are you an independent contractor for, physicians or dentists? Yes No

If yes, list all physician and dentist names, where they are insured, limits of liability and policy expiration dates:

Name	Insurer	Limits	Policy Expiration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Educational Information

Name and Type of Graduate and Post Graduate School(s) Attended	Location	Degree	Date Graduated

A. Do you have any other specialized training? Yes No

If yes, please give details: _____

B. Do you hold the certification or licensure required in your state to practice your profession? Yes No

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Applicant’s Signature: _____ Date: _____

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Authorization to Release Information

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Applicant’s Signature: _____ Date: _____

Note: ProAssurance’s Privacy Policy can be found on ProAssurance.com.

Allied Health Professional Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.

All questions must be answered or marked Not Applicable (N/A).

1. Patient's Name: _____
2. Date Reported to Insurance Company: _____
3. Name of Insurance Company: _____
4. Date of Incident and Your Treatment: _____
5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

8. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed, but dropped by claimant
- Summary Judgment in your favor
- Suit settled Out-of-Court
 Date claim paid: _____
 Amount paid: _____
 Did you want to settle this claim? Yes No

- Court outcome in your favor
 - Jury verdict
 - Directed verdict
- Court outcome in favor of plaintiff
 - Jury verdict
 - Directed verdict
- Amount of Loss: _____

- Awaiting mediation
- Awaiting court action

Reserve Amount: _____

9. Name and address of the attorney assigned to your case: _____
10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes No
 If yes, amount was: \$ _____

Name (Printed): _____

Signature: _____ Date: _____