

Limited Professional Liability Coverage Insured Paramedical Employee Renewal Application



ProAssurance Casualty Company • PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 608.828.1100

Policy #: _____ Expiring Date: _____ Specialty: _____

Agency Name: _____

Important: Please complete this form and return it **with a copy of your updated curriculum vitae** in the envelope provided. Your prompt and accurate reply will avoid any unnecessary delay of your policy's renewal. Please type or print legibly, ensuring that the form is completed in its entirety. Also, please verify that the pre-filled information below is correct. If it is not, please mark through the incorrect information and make the necessary corrections. Thank you for your cooperation.

Name: _____ Designation: _____

Social Security Number: _____ Date of Birth: _____ Sex: Male Female

Home Address: _____

City: _____ State: _____ ZIP: _____ Personal Phone: _____

Current Employer: _____

Principle Office Street Address: _____

City: _____ Practice County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____

Email Address: _____

Contact Name and Phone: _____

1. 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 Technician |
| <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Anesthesiologist Assistant | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Other, please specify: _____ | |

Number hours worked per week: _____

2. Is your employer insured by a ProAssurance company? Yes No

3. Have you ever:

- A. Been convicted of a criminal offense other than a misdemeanor? Yes No
- B. Been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management, or any mental illness including, but not limited to, depression and/or chronic fatigue? Yes No
- C. Been accused of sexual misconduct of any kind? Yes No
- D. Had a complaint filed against you with any hospital or regulatory board? Yes No
- E. Had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? Yes No

If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. is yes, please provide complete details on a separate sheet.

4. Please list the name and location of all medical schools attended:

Institution and Location	Dates Attended	Degree Obtained
_____	_____	_____
_____	_____	_____

5. Do you moonlight (work outside control of employer)? Yes No
 If yes, where? What are your responsibilities?

6. Do you have other coverage? Yes No
 If yes, name of company: _____
7. Do you hold the certification or licensure required in your state to practice your profession? Yes No
 If yes, where did you receive your training? _____
 Date(s) attended: _____
8. Have any judgments or any out-of-court settlements ever been rendered against you or on your behalf in excess of \$500 from an incident alleging professional errors or omissions? Yes No
If yes, please provide details on a separate sheet. If available, please enclose a copy of complaint.
9. Have you ever been involved in a medical professional liability claim or suit? Yes No
 The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership.
If yes, please provide details on a separate sheet. If available, please enclose a copy of complaint.
10. Has any insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage to you with any restrictions or exclusions? *(This question not applicable in Missouri)* Yes No
If yes, please provide details on a separate sheet.
11. Will you be scheduled to work at a separate location from your supervising physician? Yes No
If yes, please provide details on a separate sheet.
12. 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
13. Do you elicit, record, and evaluate a health, psychosocial, or developmental history of the patient? Yes No
14. Do you order or perform diagnostic tests? Yes No
15. Do you have prescriptive authority? Yes No
16. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referrals, and consultations when needed? Yes No
17. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes No
18. Do you perform physical examinations? Yes No
 If yes, briefly describe techniques and instruments used: _____

19. Do you conduct informed consent discussions? Yes No
 If yes, do you utilize an attorney-reviewed, standard form? Yes No
20. Describe any other procedures, treatments, or duties you perform:

21. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:

22. Please list all states in which you are licensed along with each license number and renewal date:
- | State | License Number | Renewal Date |
|-------|----------------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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.

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

Title: _____ Date: _____



Insured Physician's Authorization

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

Requested Effective Date: _____

Signature of Insured Physician/Supervising Physician

Date

Print Name

Limits Requested: _____
(For individuals being added to a physician's existing policy)

Proof of Coverage and Claims History

Insured Name: _____

Policy #: _____

ProAssurance is or was the carrier of my professional liability insurance; as such, it maintains certain information regarding my practice, including the history of any malpractice claims against me and the professional liability coverage history regarding policies in force or previously in force. I hereby authorize and request ProAssurance to release information relating to my professional liability coverage and/or claims and suits against me which is on record with any of its affiliates.

Certificate of Insurance (indicate below)

ProAssurance agrees to provide Certificates of Insurance (proof of coverage) outlining the policy number, policy period, type of insurance, and limits of liability of the insured to any hospitals, other practice entities, insurance companies or third party credentialing services listed below. ProAssurance will automatically send Certificates to the specified organizations each year until otherwise notified. The Certificate of Insurance neither affirmatively nor negatively amends, alters, or extends the coverage afforded by the policy described on the Certificate of Insurance. In the event of material change in, or cancellation of, the herein described policy, ProAssurance has no obligation to notify the party to whom the Certificate was issued, and shall not be liable in any way for failure to give such notice.

Claims History (indicate below)

ProAssurance will furnish a Claims History report showing all pending lawsuits, lawsuits closed within the last ten years, and all claims with an indemnity payment, regardless of date, upon my authorization of such action. I hereby request the release of this information relating to claims and suits against me on record with ProAssurance to the entities listed below. I understand that the information to be provided is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant. This authorization is in effect for those entities named below and considered approved for release upon request from these third parties until otherwise notified; no other verification will be required unless I notify ProAssurance otherwise regarding that information.

Signature of Insured or Insured's Representative and Title

Printed Name of Insured or Insured's Representative and Title

Date

Please use the following page to furnish us with the names and addresses of desired hospitals, entities, and third party credentialing services so we may send the requested documentation.

Certificate of Insurance Name: _____

Claims History Address Line 1: _____

Address Line 2: _____

City, State, ZIP: _____

Certificate of Insurance Name: _____

Claims History Address Line 1: _____

Address Line 2: _____

City, State, ZIP: _____

- Certificate of Insurance**
- Claims History**

Name: _____
Address Line 1: _____
Address Line 2: _____
City, State, ZIP: _____

- Certificate of Insurance**
- Claims History**

Name: _____
Address Line 1: _____
Address Line 2: _____
City, State, ZIP: _____

- Certificate of Insurance**
- Claims History**

Name: _____
Address Line 1: _____
Address Line 2: _____
City, State, ZIP: _____

- Certificate of Insurance**
- Claims History**

Name: _____
Address Line 1: _____
Address Line 2: _____
City, State, ZIP: _____