8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-678-7342 • Fax 800-498-9880

NURSE PROFESSIONAL LIABILITY

1. General Information Proposed Effective Date: ___________

Applicant is (check all that apply): o Registered Nurse (RN), o First Year Graduate Registered Nurse (RN), o Licensed Practical Nurse (LPN), o Licensed Vocational Nurse (LVN), oAides o Assistants o Nurse Practitioner (NP) o Clinical Nurse Specialist (CNS) (with prescriptive or medical diagnostic authority) o CNS (without prescriptive or medical diagnostic authority) o Other: ___________________________

Applicant's Name: ___________________________

Applicant's Mailing Address: ___________________________

City: ___________ State: ___________ Zip: ___________

E-Mail: ___________ County: ___________

Business Telephone Number: ( )___________ Fax: ( )___________

Physical Location of Business (if different): ___________________________

Population within 50 miles: ___________________________

Other Locations Used:

Physical Address: ___________________________

City: ___________ State: ___________ Zip: ___________

Physical Address: ___________________________

City: ___________ State: ___________ Zip: ___________

Please list any other names the business is or has been known by: ___________

Contact Person: ___________________________

Producer No.: ___________ Producer's Name: ___________________________

Producer's E-mail: ___________________________

2. Business Information

Detailed description of business activities (specifically, and by location): ___________________________

____

How many years have you been in business? ________

Will you be practicing as: (please check all that apply)

o An Individual (Full Name): ___________________________

o A Solo Corporation – Name of Corporation: ___________________________

Any dba's or trade names? If yes, please list: ___________________________

o A Shareho9lder of a Medical Corporation – Name of Corporation and Names of other Shareholders: ______

____

o A Partner in a Medical Partnership – Name of Partnership and Name(s) of Partner(s): ___________

____

o A Professional Association – Name of Professional and Names of Associates: ___________

____

○ An Employer – Name of Employer (Please specify if employed by an Individual, Corporation, Partnership, IPA, HMO): ____________________

____

○ An Independent Contractor – Name of Individual, Corporation or Partnership with whom you contract: _____

____

○ Sharing office space and/or expenses only – Names of Associates: ____________________

____

Are you practicing as part of any affiliation not noted above? If yes, please explain: ____________________

____

Do you employ, contract with or supervise any other healthcare providers? ○ Yes ○ No

If yes, please explain: ____________________

Name of licensed physician with whom you collaborate. ____________________

If not, please indicate your referral relationships. ____________________

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____

Annual Payroll: $ ____________________

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? ○ Yes ○ No

If yes, please tell us:

Employee Name: ____________________

E-Mail: ____________________ Business Telephone No.: ( )____________________

Fax: ( )____________________ Years with Company: ____________________

Employee's Responsibilities: ____________________

3. Insurance History

Who is your current insurance carrier (or your last if no current provider)? ____________________

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$
Coverage Limits			

If you carry malpractice insurance, where does it cover your work?

○ Home Births ○ Hospital ○ Clinics

Has any insurance carrier ever declined, surcharged, rated-up, restricted, cancelled or refused to renew your medical malpractice insurance? ○ Yes ○ No

If yes, please explain: ____________________

____

Has the Applicant or any predecessor or related person or entity ever had a malpractice claim, suit or incident?
o Yes o No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? o Yes o No

If yes, please explain: ______________________________

____

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____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?
o Yes o No

If the standard markets are declining placement, please explain why: ______________________________

____

4. Desired Insurance

Limit of Liability:

- o $100,000 per accident / $300,000 aggregate
- o $200,000 per accident / $300,000 aggregate
- o $250,000 per accident / $500,000 aggregate
- o $250,000 per accident / $1,000,000 aggregate
- o Other:______________________________

Self-Insured Retention (SIR): o $1,000 (Minimum) o $1,500 o $2,500 o $5,000 o $10,000

5. Business Activities

A. Professional Designation

o Adult, o Behavioral/Mental Health, o Community Health, o Cosmetic Procedures, o Critical Care/ICU
o Critical Care, o Emergency Room, o Family Practice, o Family Planning, o Gerontology, o Gynecology,
o Home Health Care, o Hospice, o Hospital, o Long Term Care, o Maternal & Child, o Medical – Surgical o Midwifery, o Neonatology, o Nursing Home, o Obstetrics Labor and Delivery, o Oncology,
o Pediatric, o Primary Care, o Psychiatric, o Urgent Care, o Women's Healthcare
o Other ______________________________

____

B. Describe in detail the regular operations and services you provide: ______________________________

____

____

____

C. Average/est. # of patient visits per week: ________________

D. Average/est. # of hours worked per week: ________________

State license/certification: Primary state:___________ _______Lic.# ________________

Dt. Issued: ________________Temp. exp date:_____________

Other States Licensed: ______________________________

List states, number and date

DEA Number: ______________________________

E. Person providing accounting and tax services:

a. Name: ______________________________

b. Address: ______________________________

F. Are you seeking:

a. Insurance to cover work done exclusively by you? o Yes o No

b. Insurance to cover work done by others under your direction? ○ Yes ○ No

c. Insurance to cover the actions of individuals on your payroll? ○ Yes ○ No

G. Employee breakdown (if applicable)—please enter the number of:

	Full-Time	Part-Time
Operational Staff		
Non-Operational employees (drivers, collectors, supervisors, etc.)		

H. List all Hospitals (name and location) where you have or are applying for staff privileges. ________________

____

____

____

I. Have you ever applied for admitting privileges and been turned down? ○ Yes ○ No

J. Please attach a copy of risk criteria.

____

K. Do you have transfer agreements with any hospitals? ○ Yes ○ No

If yes, please identify: ________________________________

____

L. Do you have a physician write orders? ○ Yes ○ No

M. Do you have prescriptive privileges? ○ Yes ○ No

N. Do you supervise students? ○ Yes ○ No

4. Medical Training/Education

Please include a current copy of your curriculum vitae (CV) and a copy of your practitioner/associate certificate.

Attaching a CV does not preclude the need to fully complete this application.

Institution/Program: ________________________________ ________________

NAME OF INSTITUTION CITY/ STATE COUNTRY

________________________________ From: __________ To: __________

DEGREE /CERTIFICATION MONTH/YR MONTH/YR

Other: ________________________________ ________________

NAME OF INSTITUTION CITY/ STATE COUNTRY

________________________________ From: __________ To: __________

DEGREE /CERTIFICATION MONTH/YR MONTH/YR

5. Practice Information

A. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.) **Please account for all time since training. Please explain any gaps in your education or profession practice history.**

Name of Employer	City	State	From: Mnth/Yr	To: Mnth/Yr

6. Additional Underwriting Information

If not applicable, please note with a N/A.

A. Have you ever:

1. been convicted of a crime other than a traffic violation? ○ Yes ○ No
2. suffered from or been treated for substance abuse, mental illness or serious health or physical condition? ○ Yes ○ No
3. had a complaint filed against you with an State Regulatory Board? ○ Yes ○ No
4. had any professional license/permit or narcotics license investigated, suspended, revoked, restricted or placed on probation? ○ Yes ○ No
5. been warned about your performance or placed on any type of probation during your training? ○ Yes ○ No

If you answered yes to any of the above, please explain: ____

____

____

____

____

B. Does your practice comply in every way with the rules, regulations, guidelines and standard as set forth by your State Regulatory Board? ○ Yes ○ No

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

D. Do you perform a physical examination? ○ Yes ○ No

E. Briefly describe techniques and instrument used: ____

____

____

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

G. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referral and consolation when appropriate? ○ Yes ○ No

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

I. Describe any other procedures, treatments, or duties you perform: ________________________________

____

____

____

J. Do you have any medical-related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ○ Yes ○ No if yes, please explain: ________________________________

____

K. Do you provide weight loss treatment or diet therapy? ○ Yes ○ No

L. Do you provide healthcare services to correctional facilities? ○ Yes ○ No

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that

will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: ___________________________	Dated: ___________________________
Applicant:	Agent/Broker:
____	____
Signature	Signature
____	____
Print Name	Print Name