Application for Professional Liability Coverage

Individual Allied Healthcare Providers

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

1. Current Curriculum Vitae

2. Copy of your approved notification of supervision form if you are a PA or NP

3. Copy of current professional liability insurance declarations page

4. Currently valued loss runs from all prior insurance companies

5. Copies of your practice protocols

6. Copies of all medical licenses and board certifications

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

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INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.
If the answer is NONE, state NONE;
If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A).
If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET.
NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

Name_____SSN/TIN_____DOB_____
Last First MI

Home Address_____
Street City State ZIP

If employed, Current Employer_____
Name Telephone Number

Business Address_____
Street City State ZIP

Requested Effective Date: _____ Requested Retroactive date: _____

1. Profession:

( ) Physician's Assistant	( ) Perfusionist	( ) Certified Nurse Practitioner
( ) Surgeon's Assistant	( ) Optometrist	( ) Certified Registered Nurse Anesthetist
( ) Psychologist	( ) Cytotechnologist	( ) Emergency Medical Tech
( ) Physical Therapist	( ) Radiology Tech	( ) Radiation Tech
( ) Occupational Tech	( ) Respiratory Tech	( ) Pharmacist
( ) RN/LPN	( ) Nurses Aide	( ) Phlebotomist

( ) Other (explain):_____

2. If employed, is your employer insured by Red Mountain Casualty, ProNational Insurance Company or Medical Assurance? ☐**Yes** ☐**No**

3. Have you ever:
   A. been charged with, pled guilty to, or convicted of a criminal offense? ☐**Yes** ☐**No**
   B. been treated for (or recommended for treatment of) alcoholism, sexual addiction, anger management or drug addiction? ☐**Yes** ☐**No**
   C. undergone or been recommended for psychiatric treatment? ☐**Yes** ☐**No**
   D. had a complaint filed against you with any hospital, specialty, society or regulatory board? ☐**Yes** ☐**No**
   E. had any professional license/permit investigated, suspended, revoked, restricted or placed under probation? ☐**Yes** ☐**No**
   F. failed a licensing, specialty or board certification exam? ☐**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 of paper.

4. If employed, do you moonlight (work outside control of the above employer)? ☐**Yes** ☐**No**

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

6. Where did you receive your training?

_____

7. Are you a member of any professional organization? If "Yes", please give details ☐**Yes** ☐**No**

_____

8. Have any judgments ever been rendered against you or any out-of-court settlements made on your behalf from an incident alleging professional errors or omissions? ☐**Yes** ☐**No**
If "Yes", give details on a separate sheet. If available, please enclose copy of complaint.

9. 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 "Yes", give details on a separate sheet. If available, please enclose copy of complaint.

10. Has any insurance company (including Lloyds of London) ever canceled, declined to issue or refused to renew your insurance or offered Professional Liability Insurance only on special terms? ☐**Yes** ☐**No**
If "Yes", please give details on a separate sheet.

11. Will you be scheduled to work at a separate location where there is no physician physically present? ☐**Yes** ☐**No**
If "Yes", please give 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**

Breakdown of patient services (%) by outpatient visits:

_____ % AIDS	___ % Gynecology	___ % Pediatric
_____ % Alcoholic	___ % Hemodialysis	___ % Physical Rehab
_____ % Bariatric	___ % Holistic Medicine	___ % Psychiatric
_____ % Communicable	___ % Major Surgery	___ % Research/Experimental
_____ % Dental	___ % Minor Surgery	___ % Stress Testing
_____ % Disability	___ % Nutritional (diet)	___ % Substance Abuse
_____ % Drug Addiction	___ % Obstetrical	___ % Other (describe) _____
_____ % Emergency Med.	___ % Occupational	___ % _____
_____ % Family Planning	___ % Optometry	___ % _____
_____ % General Exams	___ % Orthopedic	___ % _____

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

14. Do you order or perform diagnostic tests? ☐**Yes** ☐**No**

15. Do you discriminate between normal and abnormal findings in a history, physical examination and diagnostic tests and initiate referrals and consultations when needed? ☐**Yes** ☐**No**

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

17. Do you perform a physical examination? ☐**Yes** ☐**No**
If yes, briefly describe techniques and instruments used._____

_____

_____

18. Do you conduct informed consent discussions? ☐**Yes** ☐**No**

19. Describe any other procedures, treatments, or duties you perform. _____

_____

_____

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

_____

_____

21. Please list all states in which you are licensed, including each license number and renewal date.

State	License #	Renewal Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Perfusionists: (only perfusionsts need to complete the following)

1. ☐ I am a member, in good standing, of the American Society of Extra-Corporeal Technology, Perfusion.com or the American Academy of Cardiovascular Perfusion.

2. ☐ I am board certified by the American Board of Cardiovascular Perfusion.

3. ☐ I am not board certified, but am board eligible.
   Please explain: _____

4. ☐ My practice includes the following:

	Annual Cases	Pediatric Cases
ECMO	_____	_____
OPCAB	_____	_____
Surgical Assisting	_____	_____
Isolated limb or organ perfusion	_____	_____
VAD	_____	_____
Autologous blood salvage	_____	_____
Platelet Therapy	_____	_____
Total annual perfusion cases	_____	_____

5. ☐ My practice includes pediatric perfusion (%of pediatric cases: _____).

6. ☐ All of the following devices are employed during cardiopulmonary bypass:
   - Arterial line filter with one way valved purge line and bubble trap
   - Bubble alarm
   - Level sensor and alarm
   - Battery back up or generator
   - One way valve in the intracardiac vent/sump line

   ☐ If all are **not** used, please explain: _____

   _____

   _____

7. ☐ I use the following additional safety devises:
   - ☐ Centrifugal pump
   - ☐ A method of preventing retrograde flow while using centrifugal pump
   - ☐ In-line saturation monitor

8. ☐ I have attached a current copy of the maintenance agreement for the perfusion equipment I use.

IMPORTANT! YOU MUST READ CAREFULLY

GENERAL FRAUD WARNING

Any person who knowingly includes any false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.

Specific Consent to Conditions of Consideration of the Application for Insurance

With the submission of this 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 that may be issued to me:

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

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant who makes application for insurance and that my application will be evaluated by authorized personnel. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

_____ _____

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 liability. The following page of this Application is an **Authorization To Release Information** form which requires your signature. Please read carefully.

HEALTH CARE PROFESSIONAL LIABILITY POLICY
MID-CONTINENT GENERAL AGENCY APPLICANT WARRANTY AND AUTHORIZATION

COMPANY RECEIVING ORIGINAL APPLICATION:

The undersigned applicant acknowledges his or her previous submission of an application for professional liability insurance to the company identified above. Accordingly, the applicant has requested and authorized the transfer of his or her application and all information contained therein for consideration by Red Mountain Casualty Insurance Company, Inc., or ProNational Insurance Company and has designated the agent or broker identified below to facilitate the application. The applicant reaffirms and warrants that they have reviewed the application submitted to Mid-Continent General Agency and that all information contained in the application is true and correct and recognizes his or her responsibility to provide full and accurate information as requested in the application and to update all such information as appropriate.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by RED MOUNTAIN CASUALTY INSURANCE COMPANY, INC., OR PRONATIONAL INSURANCE COMPANY (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, any Board of Professional Examiners or Licensure Commission for any state in which he has practiced or resided, and any and all physicians or any other third party having information regarding the undersigned, to release to the Company upon its request any information that any such person or entity may have which in the judgment of such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

_____

Date: _____

Broker/Agent: _____