

NON-PHYSICIAN PERSONNEL PROFESSIONAL LIABILITY APPLICATION

NON-ASSESSABLE CLAIMS-MADE COVERAGE

- Medical Mutual Insurance Company of North Carolina
 Medical Security Insurance Company
 (both hereinafter referred to as the "Company")

Please answer all questions completely. If a question does not apply to you, write "N/A". Do not leave any question unanswered. If space is inadequate, use Comments Section (last page) or attach separate sheet.

(Please type or print in black ink.)

I. PERSONAL/PROFESSIONAL DATA

Applicant Name (last, first, middle, designation)		Date of Birth (mm/dd/yy)		
Employer Name (if applicable)				
Primary Practice Address	City	State	Zip Code	County
Residence Address	City	State	Zip Code	County
Telephone - Office ()	Fax - Office ()		E-mail Address	
Social Security Number (last 4 digits only)				

Desired Policy Dates

Effective Date: _____

Do you desire Prior Acts coverage? No Yes **If yes, Retroactive Date:** _____

If Prior Acts Coverage is requested, please complete 'Section V. (Prior Acts Coverage Certification) and attach a copy of your most recent policy declarations page.

Desired Limits (Each Claim/Aggregate)*

- | | |
|--|---|
| <input type="checkbox"/> Same as employer | <input type="checkbox"/> \$4,000,000/\$4,000,000 |
| <input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$4,000,000/\$6,000,000 |
| <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> \$5,000,000/\$5,000,000 |
| <input type="checkbox"/> \$2,000,000/\$2,000,000 | <input type="checkbox"/> \$5,000,000/\$7,000,000 |
| <input type="checkbox"/> \$2,000,000/\$4,000,000 | <input type="checkbox"/> \$6,000,000/\$6,000,000 |
| <input type="checkbox"/> \$3,000,000/\$3,000,000 | <input type="checkbox"/> \$6,000,000/\$8,000,000 |
| <input type="checkbox"/> \$3,000,000/\$5,000,000 | <input type="checkbox"/> \$2,000,000/\$6,000,000 available in Virginia only |

*Choose One Option

Applying for coverage as:

<u>Designation</u>	<u>License Number</u>
<input type="checkbox"/> Physician Assistant	_____
<input type="checkbox"/> Nurse Practitioner	_____
<input type="checkbox"/> Nurse Midwife	_____
<input type="checkbox"/> Nurse Anesthetist (CRNA)	CRNA #: _____
<input type="checkbox"/> Other:	Explain: _____

II. COVERAGE INFORMATION

1. Professional/Clinical Education:

A. Medical Education:	State	From	To	Date of Graduation:
B. Medical Education:	State	From	To	Date of Graduation:

2. Professional/Clinical Experience:

A. Employment (Most Recent):	State	From	To
B. Employment (Prior Experience):	State	From	To
C. Employment (Prior Experience):	State	From	To

3. Specify type of Diploma/Certification received and dates for each:

4. Do you currently belong to any national organizations?

No Yes - please specify: _____

5. How many hours will you work per week, on average with this employer? _____

6. Do you "moonlight" outside the employment of this employing physician or group?

No Yes – please explain including name of employer, type of work and hours: _____

7. Are you presently covered as an individual insured on another professional liability insurance policy? No Yes

If yes, will that policy continue in force? No Yes - please explain: _____

(If "yes", please submit a Certificate of Insurance to verify coverage.)

III. INSURANCE HISTORY

Please list insurance information for the past ten (10) years or back to requested retroactive date, whichever is longer.

1. **Carrier Information:**

	Current Carrier	First Prior Carrier	Second Prior Carrier	Third Prior Carrier	Fourth Prior Carrier
Insurance Company					
Policy Number					
Coverage form	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Dates of Coverage					
Limit of Liability Per claim/aggregate					
Deductible or S.I.R. and amount (If applicable)	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R. \$	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R. \$	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R. \$	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R. \$	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R. \$
Retroactive Date					

2. Has your professional/clinical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted in any location? No Yes - Explain: _____

3. Has any professional liability carrier ever cancelled or non-renewed your coverage or surcharged your premium? No Yes - Explain: _____

4. Have you ever been or are you currently under a "consent order"? No Yes - Attach copy

5. Have you ever been diagnosed with, or treated for, alcoholism, drug addiction, or mental or physical impairment? No Yes - Explain and provide dates and locations of all treatment or evaluations as well as names of your supervising and/or monitoring physicians. _____

6. Have you ever been questioned, investigated, or requested to appear before any of the following:

- A. A state licensing board or equivalent? Yes No
- B. A specialty or medical association? Yes No
- C. A Medicare/Medicaid agency? Yes No
- D. Other? Yes No

If "Yes"- Explain: _____

7. Have you ever been charged with any criminal activity?

No Yes - Explain: _____

8. Has any claim or suit for alleged sexual misconduct ever been brought against you?

No Yes - Explain: _____

9. Have your hospital privileges been denied, restricted, suspended, revoked, or voluntarily surrendered within the past 3 years?

No Yes - Explain: _____

IV. CLASSIFICATION

Please answer the applicable questions in the section below.

1. Physician Assistant (PA) or Nurse Practitioner (NP)

- A. Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the board?

No Yes- If yes, please attach evidence of approval. If no, what is the status of your approval? Please explain _____

COVERAGE CANNOT BE ISSUED WITHOUT SITE AND SUPERVISOR APPROVAL FROM THE BOARD.

- B. Check the sites where you will perform your duties:

Office with supervising physician always present Hospital
Office with supervising physician occasionally present Emergency Room

- C. What is the arrangement for you and your supervisor's continuous availability for supervision, consultation, collaboration, and evaluation of your medical acts? _____

- D. If you are primarily practicing in an emergency room setting, are you supervised by the direct physical presence of the physician employing you? No Yes N/A

If "No", please explain: _____

2. Nurse Midwife

- A. Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the board?

No Yes- If "Yes", please attach evidence of approval. If "No", what is the status of your approval? Please explain _____

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- B. Are you familiar with the Approved Formulary for the writing of prescriptions by persons licensed and approved to practice Midwifery? No Yes

- C. Do you perform or assist with deliveries in non-hospital settings? No Yes

- D. Do you practice at a site away from the direct supervision of your approved supervising physician? No Yes - please explain: _____

3. Nurse Anesthetist

- A. Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the board?

No Yes- If "Yes", please attach evidence of approval. If "No", what is the status of your approval? Please explain _____

COVERAGE CANNOT BE ISSUED WITHOUT SITE AND SUPERVISOR APPROVAL FROM THE BOARD.

- B. Do you administer anesthesia when an anesthesiologist is not physically present?

No Yes - please explain: _____

- C. Do you ever administer anesthesia under the supervision of a physician other than an Anesthesiologist? No Yes - please explain: _____

V. CLAIMS HISTORY

ATTACH CURRENT *LOSS RUN* (no more than 90 days old) FOR PREVIOUS 10 YEARS OF PRACTICE. (A *loss run* is a document from your professional liability carrier(s) verifying claims, suits or reported incidents.) YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

1. Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services? No Yes
2. Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you? No Yes

IF "YES" TO 1 OR 2 ABOVE, PLEASE COMPLETE THE FOLLOWING FOR EACH SUCH CIRCUMSTANCE. IF YOU NEED MORE SPACE, USE "COMMENTS SECTION" OR ATTACH ADDITIONAL SHEET. FOR PAID CLAIMS, PLEASE ATTACH A COPY OF THE NATIONAL PRACTITIONER DATA BANK SUBMISSION.

CLAIM, SUIT OR INCIDENT #1

Patient's Name	Date of Occurrence
Insurance Carrier	Location of Occurrence
Date Claim reported: <input type="checkbox"/> N/A	Amount reserved on your behalf \$
Date Claim closed: <input type="checkbox"/> N/A	Amount paid on your behalf \$
Allegation(s):	

CLAIM, SUIT OR INCIDENT #2

Patient's Name	Date of Occurrence
Insurance Carrier	Location of Occurrence
Date Claim reported: <input type="checkbox"/> N/A	Amount reserved on your behalf \$
Date Claim closed: <input type="checkbox"/> N/A	Amount paid on your behalf \$
Allegation(s):	

V. CLAIMS HISTORY (continued)

CLAIM, SUIT OR INCIDENT #3

Patient's Name		Date of Occurrence
Insurance Carrier		Location of Occurrence
Date Claim reported:	<input type="checkbox"/> N/A	Amount reserved on your behalf \$
Date Claim closed:	<input type="checkbox"/> N/A	Amount paid on your behalf \$

Allegation(s):

VI. PRIOR ACTS COVERAGE CERTIFICATION

(Complete if Prior Acts Coverage is requested in Section I. Personal/Professional Data.)

I request Prior Acts Coverage retroactive to: _____ (date), which is consistent with the attached Declarations page from my current carrier.

I certify that I have no knowledge of any professional liability claims which have been asserted against me, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior applicable carrier.

I furthermore certify I have no knowledge of any occurrence, incident or circumstance likely to result in such a claim as of this date, other than those reported on this application.

Notice of any such claim(s), occurrence(s), incident(s) or circumstance(s) should be given to your current carrier if such notice has not already been provided. This policy will not provide coverage for any such claim, occurrence, incident or circumstance.

I certify that the above is true, complete and correct to the best of my knowledge, information and belief. I understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

Signature of Applicant

Date

VII. AUTHORIZATION AND RELEASE

(This authorization and release must be signed by the Applicant.)

I, the undersigned Applicant, understand that this is an application and is not an insurance binder and acknowledge that the foregoing statements and answers are complete and correct to the best of my knowledge and belief. I further understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

I, the undersigned Applicant, authorize the release and exchange of information involving either underwriting or claim matters between my present or prior insurance carrier, any hospital and other physicians and the Company. I hereby release and agree to hold harmless all persons or organizations releasing information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, or agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization.

Signature of Applicant

Date

Name and Address of Agent:

Signature of Agent

Date

NOTICE TO VIRGINIA RESIDENTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Please return completed application to your agent or to the Company:

Attention: Underwriting Department
PO Box 98028
Raleigh, NC 27624-8028

