



First Professionals Insurance Company

Application

*FOR PROFESSIONAL
ANCILLARY EMPLOYEES*

Medical Professional Liability Insurance Policy
Claims-Made
Non-Assessable



Ancillary Employee Application

Application for Professional Liability Insurance
Employed by Current FPIC Policyholders

RETURN APPLICATION TO:
Your Insurance Agent or
First Professionals Insurance Company
1000 Riverside Avenue, Suite 800
Jacksonville, FL 32204
Mailing Address: P. O. Box 44033
Jacksonville, FL 32231-4033
904-354-5910 • 1-800-741-3742
Fax: 904-358-6728
www.firstprofessionals.com

Please type or print

All statements below must be completed and all questions answered completely.

PLEASE DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER OR POLICY FROM THIS COMPANY HAS BEEN RECEIVED AND IS IN EFFECT.

PERSONAL INFORMATION

1. Name _____ Social Security No. _____

2. Mailing Address _____
(Street/P. O. Box) (City/State/Zip)

3. Date of Birth _____ Place of Birth _____

4. _____
Phone Number Fax Number E-Mail Address

5. a. For the following occupations, complete this application ONLY IF REQUESTING COVERAGE SEPARATE FROM EMPLOYER. Shared coverage is provided automatically and does not require an application:

- | | | |
|--|---|---|
| <input type="checkbox"/> Certified Nursing Assistant | <input type="checkbox"/> O.R. Technician (Hospital) | RN: <input type="checkbox"/> Critical Care |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Optician | <input type="checkbox"/> ER |
| <input type="checkbox"/> Dietitian/Nutritionist | <input type="checkbox"/> Paramedic | <input type="checkbox"/> First Assist |
| <input type="checkbox"/> LPN, LVN, Aide, and First Year RN | <input type="checkbox"/> Perfusionist-Heart/Lung | <input type="checkbox"/> General Duty |
| <input type="checkbox"/> Med. Laboratory Technician | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> OB |
| <input type="checkbox"/> Mental Health Counselor | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Scrub |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Psychotherapist | <input type="checkbox"/> Surgeon Assistant |
| <input type="checkbox"/> Respiratory Therapist | <input type="checkbox"/> Other * _____ | |

*Describe General Duties _____

b. For the following occupations, an application must be completed in all cases, including the application supplement on page 7. Please indicate whether the requested coverage is to be shared with the employer or separate from the employer.

- Nurse Anesthetist Nurse Practitioner Physician Assistant Nurse Midwife

I request: (select one) Separate limits from employer Shared limits with employer

6. I request an Effective Date of 12:01 a.m. on _____ Retroactive Date _____

I request policy limits of: (select one)

\$250,000/\$750,000

\$500,000/\$1,500,000

\$1,000,000/\$3,000,000

7. Type of Certification/License you currently hold. (Attach copy to this application.)

8. List the states where you practice and license numbers, if applicable:

State	% of Practice in State	License Number	License Status Active?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

9. **Have you ever:**

a. Had your license or certification suspended, denied, revoked, or restricted in any state? YES NO

b. Had your insurance for medical malpractice refused, cancelled, suspended, nonrenewed, declined, or accepted on special terms? YES NO

c. Had any fee or professional relations complaints registered against you with your association(s), hospital(s), state licensing authority, or certifying body? YES NO

d. Been denied staff or hospital privileges or had privileges suspended, terminated or revoked? YES NO

e. Been treated or hospitalized for any mental or emotional disorders? YES NO

f. Incurred or become aware of having an illness or physical disability which impairs or could impair your ability to perform your duties? YES NO

g. Been charged with or convicted of a felony or misdemeanor other than minor traffic violations? YES NO

h. Been treated or hospitalized for use of any of the following:

i. alcohol YES NO

ii. narcotics YES NO

iii. central nervous system stimulants or depressants YES NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET OF PAPER.

MEDICAL EDUCATION

10. Institution _____ State _____ Degree/Certificate _____

Dates from _____ to _____ Date Graduated _____

Institution _____ State _____ Degree/Certificate _____

Dates from _____ to _____ Date Graduated _____

11. Describe any continuing medical education courses that you completed within the past two years.

WORK EXPERIENCE (for the last 7 years)

12. a. Employer	Address	Dates Employed
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Do you treat patients at a nursing home, assisted living facility, jail or correctional facility? YES NO
 If yes, please explain: _____

c. Do you want this FPIC coverage to protect you for an exposure outside the scope of your employment by the FPIC insured? YES NO
 If yes, please explain: _____

PRIOR PROFESSIONAL LIABILITY INSURANCE

13. Name of Insurance Co.	Insurer Policy No.	Policy Period	Claims-Made or Occurrence	Retroactive Date

(Attach copy of current coverage summary sheet.)

CLAIMS INFORMATION

14. Have you ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last fifteen (15) years, including any expression of an intent (i.e. closed records requests, incident reports and Notices of Intent, even if suit was never filed), or are you presently involved in malpractice litigation? YES NO

If Yes, submit a separate form for each case in the last fifteen (15) years (See page 5)

15. Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit:
- a. A request for records from a patient and/or attorney related to an adverse outcome? YES NO
 - b. A letter or communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient? YES NO
 - c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? YES NO
 - d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?
 - i. Cardiac arrest YES NO
 - ii. Postoperative coma YES NO
 - iii. Postoperative neurological deficits YES NO
 - iv. Unexpected death within 48 hrs. postoperatively YES NO

16. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? YES NO

17. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits (**EVEN IF YOU BELIEVE THE OUTSTANDING CLAIM OR SUIT WOULD BE WITHOUT MERIT**) that have not been reported to your current OR prior professional liability carrier? If yes, please explain _____ YES NO

18. Has any other party (e.g. current or prior employer, physician, etc.) been the subject of a claim due to your actions? YES NO

(Complete supplementary claims information form on each claim or suit.)

CLAIMS INFORMATION FORM

Patient's Name _____

Address _____

Incident Date _____ Date Reported to Carrier _____

Insurance Carrier _____ Policy number _____

Name of Attorney representing you _____

Address of Attorney representing you _____

Name of supervising physician _____

Treatment Rendered _____

Allegations _____

What is the present condition of this patient? _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, pertaining to this claim? YES NO

Present status of claim (check applicable answers):

- Suit threatened, no action taken
- Dropped by claimant
- Summary judgment in your favor
- Court trial in your favor
- Notice of intent filed
- Suit filed:
Reserve amount \$ _____
- Out of court settlement:
Date paid _____ Amount paid \$ _____
- Court settlement:
Date paid _____ Amount paid \$ _____

The above is a true and correct statement. By signing this form, I hereby authorize my prior insurance company to release any claim information requested by FPIC.

Date: _____ Signature of Applicant: _____

(A photostatic copy of this authorization shall be considered as effective and as valid as the original.)

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with First Professionals Insurance Company (FPIC). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences or circumstances related to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of FPIC in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by FPIC and I am notified of said acceptance. Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by FPIC. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Resource Network, individuals and FPIC. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source. I understand that, if I am insured by FPIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with FPIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FPIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FPIC.

Date _____ Signature of Applicant _____

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or FPIC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

FRAUD STATEMENT
Section 817.234(1)(b), Florida Statutes (if applicable)

The statute requires the statement to contain in substance the following language: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

PLEASE ATTACH THE FOLLOWING

- a) Copy of your resume or CV.
- b) Copy of applicable office protocols filed with the state.
- c) Copy of your medical license or copy of certificate issued by the state.

APPLICATION SUPPLEMENT
Applies to Nurse Practitioners, Nurse Midwives, CRNAs, and PAs

1. Describe role, activities and functions to be performed by the applicant in the office setting:

2. Describe role, activities and functions to be performed by the applicant in the hospital setting:

3. Describe role, activities and functions to be performed by the applicant in other practice setting:

4. Describe in detail the acts, tasks and functions that the applicant will be allowed to perform under indirect supervision (i.e. away from your presence), and the safeguards (standing orders, backup arrangements, access via telephone, etc.) which you have established for the protection of the patient.

The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

Date

Signature of Applicant

Date

Signature of Applicant's Physician-Employer

Employer's Medical License Number

Employer's FPIC Policy Number