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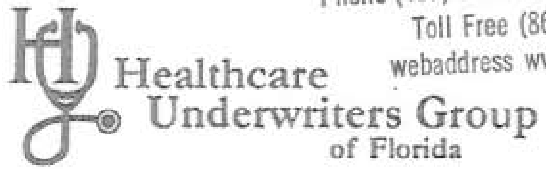

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NON-PHYSICIAN HEALTH CARE PROVIDER PROFESSIONAL LIABILITY INSURANCE APPLICATION

Section I --General Information (All questions must be completed. If question does not apply, answer "no" or "none")

1. Name and address of applicant

Name: ______________________________

____

Address: ______________________________

____

City: __________ State: __________ Zip: __________

Contact person: ______________________________

Phone: ______________________________

Fax: ______________________________

E-Mail: ______________________________

Requested Effective date ______________________________

2. Birth Date ______________ 3. Social Security Number ______________

4. List below all locations where you work.

Employer	Street	City	County	State	Zip	Specialty	# hrs per mo	Phone

5. Do you practice as:

☐ Graduate Nurse
☐ Licensed Practical Nurse
☐ Nurse Anesthetist
☐ Nurse midwife – deliveries
☐ Nurse midwife – no deliveries
☐ Nurse Practitioner Specialty ______________
☐ Clinical Nurse Specialist
☐ Optician
☐ Optometrist
☐ Pharmacist
☐ Physical Therapist
☐ Physician's Assistant (with surgical assisting?) ☐ Yes ☐ No
☐ Psychiatric Nurse
☐ Registered Nurse
☐ Student nurse
☐ X-Ray Therapist
☐ First Nurse Surgical Assistant
☐ Dental Assistant/Hygienist
☐ Licensed Counselor
☐ Social Worker
☐ Psychologist
☐ Other (describe) ______________________________

Please attach a copy of all licenses and/or certifications

6. **Type of practice (Check all that apply)**

☐ Employed Provider
☐ Professional Association
☐ Partnership
☐ Sole Proprietor/Unincorporated
☐ Independent Contractor
☐ Other (describe) ______________
☐ Limited Liability Corporation
☐ Principal in a Professional Corporation

7. List all states in which you are or have ever been licensed or certified.

State	License #	Certificate #	Current Yes/No

Please answer questions below in detail, and be certain to fully address any "Yes" answers

8.. Has your professional license ever been denied, suspended, revoked or Voluntarily surrendered or has probation been invoked? ☐ Yes ☐ No

9. Are you currently aware of any investigation being conducted which could impact your license? ☐ Yes ☐ No

10. School of graduation ______________________ Degree __________ Date __________

11. Provide detailed description of your principal activity while working.

12. Do you provide any service over the Interne or through a telemedicine program? ☐ Yes ☐ No

13. Percentage of practice by state.

State	% of patients	% of hospital	% of office hours

14. Has your employment ever been terminated? ☐ Yes ☐ No

15. Are you currently being, or have you ever been, treated for alcoholism or substance abuse? ☐ Yes ☐ No

16. Have you ever had a claim or other action based on any alleged professional negligence brought against you or have you ever been accused of professional negligence? ☐ Yes ☐ No

If YES, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage? ☐ Yes ☐ No

Please provide completed details for each incident on the Supplemental Claims Information Form and attach to this application. The name of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amount or current status must be included.

17. Do you have knowledge of any claims, potential claims, circumstances that could possibly result in claims, or suits in which you may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim? ☐Yes ☐ No

If YES, has this incident (these incidents) been reported to a prior insurer? ☐ Yes ☐ No

Please provide completed details for each incident on the Supplemental Claims Information Form and attach to this application. The name of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amount or current status must be included.

18. Name of current professional liability insurance carrier. ______________________

Policy Number ______________________ Expiration Date ______________

Type of Coverage: ☐ Occurrence ☐ Claims-Made

If Claims-Made, was tail coverage purchased? ☐ Yes ☐ No

19. Has any company ever cancelled, not renewed or refused coverage? ☐ Yes ☐ No

____

20. Do you follow all state laws, federal laws and specific national association protocols? ☐ Yes ☐ No

If "No", please explain and attach a copy of the protocols followed:

Section II – Signature
This section must be completed by all applicants.

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind Healthcare Underwriters Group to complete the insurance, but it is agreed that this application shall be the basis of a contract should a policy be issued. I authorize, release and exchange of any underwriting or claims information between all prior carriers and Healthcare Underwriters Group.

Notice to Florida Applicants: 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.

____
Signature of Applicant **Date**

I understand that Healthcare Underwriters Group reserves the right to reject any applicant that does not meet its underwriting standards.

____
Florida Licensed Agent Signature **License Number** **Date**

Supplemental Claims Information

This form should be completed for each claim or incident
Attached separate sheet if necessary

Name of Applicant:____

1. Claimant's / plaintiff's name/age/sex: ____
2. Date(s) care rendered:____________________
3. Date claim was reported to carrier: ______________
4. Were there additional defendents? ☐ Yes ☐ No

   IF YES, Please list:____
5. Status ☐ open ☐closed Date claim closed ________________
6. IF CLOSED, how was claim resolved? Check answer:

   ☐ Jury Trial ☐ Mediation ☐ Settlement ☐ Dismissed
7. IF CLOSED, was any indemnity payment or award made? ☐ yes ☐ no
   If yes, total amount of settlement: $________________
   Amount paid on your behalf: $________________
8. Name of insurance company ____
9. Allegations made against you:

   ____

   ____

   ____
10. Type of treatment, result of treatment, your involvement:

    ____

    ____

    ____
11. Subsequent condition or health of patient:

    ____

    ____

    ____

______________________________ ______________________________
Date This Form Completed Signature of Applicant