



PROFESSIONAL LIABILITY ASSOCIATION, INC.
RISK RETENTION GROUP, INC.

NON-PHYSICIAN HEALTH CARE PROVIDER
PROFESSIONAL LIABILITY INSURANCE APPLICATION

Section I - General Information (All questions must be completed.)

1. Policy Name: \_\_\_\_\_

Applicant Name \_\_\_\_\_

Address: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

2. Effective Date \_\_\_\_\_ Retro Date \_\_\_\_\_

3. Birth Date: \_\_\_\_\_

4. Social Security #: \_\_\_\_\_

5. List all locations where you work.

Table with 6 columns: Employer, Street, City, State, Zip, Specialty and 3 columns: # hrs per month, #patients per month, Phone.

6. Do you practice as:

- Checkboxes for Nurse Anesthetist, Nurse Midwife - Deliveries, Nurse Midwife - No Deliveries, Nurse Practitioner, Other (Describe), Perfusionist, LPN, RN, Optometrist, Physician's Assistant, Pharmacist, First Surgical Assistant, Psychologist.

Please attach a copy of all licenses and/or certifications.

7. Describe practice including any procedures you perform:

Three horizontal lines for describing practice.

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

Table with 8 columns: State, License #, Certificate #, Current Yes/No, % per State, % of patients, % of hospital, % of Office Hours.

9. Name of Supervising Physician: \_\_\_\_\_

Name of Active Physician \_\_\_\_\_

**Please explain, in detail, any "Yes" answers to questions 10-15 on a separate piece of paper**

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

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

12. School of graduation \_\_\_\_\_ Degree \_\_\_\_\_ Date \_\_\_\_\_

13. Provide detailed description of your principal activity while working including any procedures you perform.

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Are those activities supervised?  Yes  No

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

**Please provide completed details for each incident (questions 16-17) on a Professional Liability 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.**

16. Have you ever had a claim or other action based on any alleged professional negligence brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged or have you been accused of professional negligence?  Yes  No \_\_\_\_\_ How many?  
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

17. Do you have knowledge of any claims, potential claims, circumstances that could possibly result in claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, 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

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 you 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 CARE Professional Liability Association, Inc. 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 any exchange of any underwriting or claims information between all prior carriers and CARE Professional Liability Association, Inc.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

I understand that CARE Professional Liability Association, Inc. reserves the right to reject any applicant that does not meet its underwriting standards.