

Applicant's Name _____

Effective Date of Coverage _____

PRACTICE INFORMATION

Practice Name _____ Office Phone _____

Corporate Office Address _____ Office Fax _____

City _____ State _____ Zip Code _____

LICENSURE AND CERTIFICATION

I am applying for coverage as a:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Nurse Surgical Assistant | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Nurse Anesthetist (CRNA) | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Radiology Technician |
| <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Optician | <input type="checkbox"/> Psychologist | Other: _____ |
| <input type="checkbox"/> Nurse Practitioner (CRNP) | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Physical Therapist | _____ |

PA License Number (If applicable) _____ Additional Certifications _____

WORK SETTING/HOURS

Please check all that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Primary Physician Office | <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Hospital Operating Suite | <input type="checkbox"/> Ambulatory Surgery Center |
| <input type="checkbox"/> Specialty Physician Office | <input type="checkbox"/> Trauma Center | <input type="checkbox"/> Hospital In-Patient Unit | <input type="checkbox"/> Other Outpatient Facility |
| <input type="checkbox"/> Psychiatric Facility | <input type="checkbox"/> Nursing Home/Extended Care Facility | | |

Average hours worked per week Please indicate the average total hours worked per week for this practice:
(Worked hours includes patient care, hospital rounds, record-keeping, administrative duties, teaching, house-calls, nursing home visits and utilization review)

10 or less hours 21-29 hours
 11-20 hours 30 or more hours

SCOPE OF PRACTICE

Please check all that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Assist in surgery | <input type="checkbox"/> Pre or post operative care | <input type="checkbox"/> Emergency or critical care <10 hrs per week |
| <input type="checkbox"/> Diagnostic management | <input type="checkbox"/> Obstetrical care | <input type="checkbox"/> Emergency or critical care >10 hrs per week |
| <input type="checkbox"/> Ordering/interpreting diagnostic testing | <input type="checkbox"/> Prescribe medications | <input type="checkbox"/> After hours/weekend call |
| <input type="checkbox"/> Perform physical assessments | <input type="checkbox"/> Pediatric care | _____ |
| <input type="checkbox"/> Compile patient histories | <input type="checkbox"/> Anesthesia administration | _____ |

Applicant's Signature _____

Date _____

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HOSPITAL PRIVILEGES

Hospital Name	City, State	Type of Privileges	Specialty or Department

INSURANCE HISTORY

	Current Policy	First Prior Policy
Name of Carrier		
Type of policy	___ Claims-Made ___ Occurrence	___ Claims-Made ___ Occurrence
Effective date		
Expiration date		
Retroactive date		

COVERAGE REQUESTED

Type of coverage requested: Limits of Liability requested:
 ___ Claims-Made Coverage ___ \$500,000 per claim/\$1,500,000 Annual Aggregate
 ___ Occurrence Coverage ___ \$1,000,000 per claim/\$3,000,000 Annual Aggregate*
 * Certified Registered Nurse Practitioners and Physicians Assistants are required to obtain limits of \$1,000,000/\$3,000,000

PRIOR ACTS COVERAGE

If your prior policy is a "CLAIMS-MADE" policy, you must either purchase prior acts coverage through this policy or obtain an extended reporting period endorsement (tail) from your prior carrier.

If you DO NOT WANT or DO NOT NEED prior acts coverage, please indicate this decision by signing in the space provided. By signing, you are acknowledging that your retroactive date of coverage WILL BE THE SAME as your effective date of coverage.	I decline or do not need retroactive coverage
	Applicant Signature

ADDITIONAL INFORMATION

Within the past seven (7) years have you been the subject of any complaint, charge or disciplinary action against you for any reason by a court, licensing board, hospital, or regulatory agency responsible for enforcing or maintaining the standards of your profession?	<u>Yes</u>	<u>No</u>
Have you ever had your professional liability insurance declined, cancelled or non-renewed for any reason?	<u>Yes</u>	<u>No</u>
Please provide a brief explanation for either question above:		

Applicant's Signature _____ Date _____

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PROFESSIONAL LIABILITY HISTORY

Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior or current insurer?		Yes		No
Has any claim or suit for alleged malpractice been brought against you in the prior ten (10) years?		Yes		No
Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?		Yes		No

Please provide a brief explanation for each situation which requires a "YES" answer to any of the prior three questions:

1.
2.
3.
4.

The undersigned agrees to fully comply with the conditions of membership in CPPRRG and understands that noncompliance may result in a non-renewal of coverage. The undersigned declares that to the best of his or her knowledge and belief that the statements set forth herein are true. Although the signing of this application does not bind the undersigned on behalf of the applicant or its organization or other insured person to effect insurance, the undersigned agrees that this application and its attachments shall be the basis of the contract should a policy be issued and shall be attached to and form part of this policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such a person to criminal and civil penalties.

The policy you are applying for will be issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance guaranty funds are not available for your risk retention group.

Applicant's Signature _____

Date _____