Limited Professional Liability Insurance Renewal Application for Insured Paramedical Employees

PROASSURANCE
Treated Fairly

ProAssurance Indemnity Company, Inc. • PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 205.414.2895

Policy #: _____ Expiring Date: _____ Specialty: _____

Agency Name: _____

Important: Please complete this form and return it **with a copy of your updated curriculum vitae** in the envelope provided. Your prompt and accurate reply will avoid any unnecessary delay of your policy's renewal. Please type or print legibly, ensuring that the form is completed in its entirety. Also, please verify that the pre-filled information below is correct. If it is not, please mark through the incorrect information and make the necessary corrections. Thank you for your cooperation.

Name: _____ Designation: _____

Social Security Number: _____ Date of Birth: _____ Sex: Male ☐ Female ☐

Home Address: _____

City: _____ State: _____ ZIP: _____ Personal Phone: _____

Current Employer: _____

Principal Office Street Address: _____

City: _____ Practice County: _____ State: _____ ZIP: _____

Office Phone: _____ Office Fax: _____

Email Address: _____

Contact Name and Phone: _____

1. Profession:

☐ Physician Assistant	☐ Perfusionist	☐ Certified Nurse Practitioner
☐ Surgical Assistant	☐ Optometrist	☐ Certified Registered Nurse Anesthetist
☐ Psychologist	☐ Cytotechnologist	☐ Emergency Medical Technician
☐ Certified Nurse Midwife	☐ Anesthesiologist Assistant	☐ Clinical Nurse Specialist
☐ Audiologist	☐ Other, please specify: _____	

Number hours worked per week: _____

2. Is your employer insured by a ProAssurance company? Yes ☐ No ☐

3. Have you ever:
   - A. Been convicted of a criminal offense other than a misdemeanor? Yes ☐ No ☐
   - B. Been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics, or any other substance abuse, sexual addiction, anger management, or any mental illness including, but not limited to, depression and/or chronic fatigue? Yes ☐ No ☐
   - C. Been accused of sexual misconduct of any kind? Yes ☐ No ☐
   - D. Had a complaint filed against you with any hospital or regulatory board? Yes ☐ No ☐
   - E. Had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? Yes ☐ No ☐

   If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. is yes, please provide complete details on a separate sheet.

4. Please list the name and location of all medical schools attended:

Institution and Location	Dates Attended	Degree Obtained

Name: _____ Policy #: _____ Expiring Date: _____

5. Do you moonlight (work outside control of employer)? Yes ☐ No ☐
   If yes, where? What are your responsibilities?

   _____

   _____

6. Do you have other coverage? Yes ☐ No ☐
   If yes, name of company: _____

7. Do you hold the certification or licensure required in your state to practice your profession? Yes ☐ No ☐
   If yes, where did you receive your training? _____

   Date(s) attended: _____

8. Have any judgments or any out-of-court settlements ever been rendered against you or on your behalf in excess of $500 from an incident alleging professional errors or omissions? Yes ☐ No ☐
   If yes, please provide details on a separate sheet. If available, please enclose a copy of complaint.

9. Have you ever been involved in a medical professional liability claim or suit?
   The word "claim" as used in this question refers to any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee, or professional corporation or partnership. Yes ☐ No ☐
   If yes, please provide details on a separate sheet. If available, please enclose a copy of complaint.

10. Has any insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage to you with any restrictions or exclusions? *(This question not applicable in Missouri)* Yes ☐ No ☐
    If yes, please provide details on a separate sheet.

11. Will you be scheduled to work at a separate location from your supervising physician? Yes ☐ No ☐
    If yes, please provide details on a separate sheet.

12. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? Yes ☐ No ☐

13. Do you elicit, record, and evaluate a health, psychosocial, or developmental history of the patient? Yes ☐ No ☐

14. Do you order or perform diagnostic tests? Yes ☐ No ☐

15. Do you have prescriptive authority? Yes ☐ No ☐

16. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referrals, and consultations when needed? Yes ☐ No ☐

17. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes ☐ No ☐

18. Do you perform physical examinations? Yes ☐ No ☐
    If yes, briefly describe techniques and instruments used: _____

    _____

19. Do you conduct informed consent discussions? Yes ☐ No ☐
    If yes, do you utilize an attorney-reviewed, standard form? Yes ☐ No ☐

20. Describe any other procedures, treatments, or duties you perform:

    _____

    _____

21. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:

    _____

    _____

22. Please list all states in which you are licensed along with each license and NPI number and renewal date:

State	License Number/NPI Number	Renewal Date

Name: _____ Policy #: _____ Expiring Date: _____

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Intent to Join Virginia Purchasing Group

The undersigned insured hereby consents to join the ProAssurance Healthcare Providers Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

Consent to Conditions of Consideration of the Application for Insurance

I understand that no coverage will be bound until after ProAssurance has reviewed my completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, my advance payment will be promptly returned to me.

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me.

To the fullest extent permitted by law, I extend absolute immunity to and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I understand that should any incident, injury or death occur to any patient while under my care subsequent to my signing and dating this application, I must notify ProAssurance or its authorized agent or broker in writing of such event.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following section is an Applicant's Representation and Authorization from which requires your signature. Please read carefully.

Applicant's Representation and Authorization

I, the undersigned, hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon my acceptability to ProAssurance and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name (Printed): _____

Applicant's Signature: _____

Title: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

Insured Physician's Authorization

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

Requested Effective Date: _____

_____ _____

Signature of Insured Physician/Supervising Physician Date

_____

Print Name

Limits Requested: _____
(For individuals being added to a physician's existing policy)

Proof of Coverage and Claims History

Insured Name: _____

Policy #: _____

ProAssurance is or was the carrier of my professional liability insurance; as such, it maintains certain information regarding my practice, including the history of any malpractice claims against me and the professional liability coverage history regarding policies in force or previously in force. I hereby authorize and request ProAssurance to release information relating to my professional liability coverage and/or claims and suits against me which is on record with any of its affiliates.

Certificate of Insurance (indicate below)

ProAssurance agrees to provide Certificates of Insurance (proof of coverage) outlining the policy number, policy period, type of insurance, and limits of liability of the insured to any hospitals, other practice entities, insurance companies or third party credentialing services listed below. ProAssurance will automatically send Certificates to the specified organizations each year until otherwise notified. The Certificate of Insurance neither affirmatively nor negatively amends, alters, or extends the coverage afforded by the policy described on the Certificate of Insurance. In the event of material change in, or cancellation of, the herein described policy, ProAssurance has no obligation to notify the party to whom the Certificate was issued and shall not be liable in any way for failure to give such notice.

Claims History (indicate below)

ProAssurance will furnish a Claims History report showing all pending lawsuits, lawsuits closed within the last ten years, and all claims with an indemnity payment, regardless of date, upon my authorization of such action. I hereby request the release of this information relating to claims and suits against me on record with ProAssurance to the entities listed below. I understand that the information to be provided is highly confidential and should not be disclosed in any manner that would cause such information to benefit any claimant. This authorization is in effect for those entities named below and considered approved for release upon request from these third parties until otherwise notified; no other verification will be required unless I notify ProAssurance otherwise regarding that information.

_____

Signature of Insured or Insured's Representative and Title

_____

Printed Name of Insured or Insured's Representative and Title

_____

Date

Please use the following page to furnish us with the names and addresses of desired hospitals, entities, and third party credentialing services so we may send the requested documentation.

☐ **Certificate of Insurance**
☐ **Claims History**

Name: ____________________
Address Line 1: ____________________
Address Line 2: ____________________
City, State, ZIP: ____________________

☐ **Certificate of Insurance**
☐ **Claims History**

Name: ____________________
Address Line 1: ____________________
Address Line 2: ____________________
City, State, ZIP: ____________________

☐ **Certificate of Insurance**
☐ **Claims History**

Name: ____________________
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Address Line 1: ____________________
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