

CBMALAGA

Insurance Services LLC

Allied Health Professional Liability Insurance Application Form

THIS APPLICATION IS FOR THE FOLLOWING PROFESSIONALS

Physician's Assistant	Perfusionist	Certified Nurse Practitioner
Surgeon's Assistant	Optometrist	Certified Registered Nurse Anesthetist
Psychologist	Cytotechnologist	Emergency Medical Tech
Physical Therapist	Radiology Tech	Radiation Tech
Occupational Tech	Respiratory Tech	Pharmacist
RN/LPN	Phlebotomist	Certified Nurse Midwife

With your fully completed, signed and dated application, you **must** submit the following information:

1. Current insurance policy declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Articles of Incorporation, if applicable.
5. Loss runs from all prior insurance companies or explanation as to why they are not available.
6. Copy of curriculum vitae.

Note: Submission of a completed application confers no obligation upon the Company to bind coverage.

1-877-245-5887
Return application by fax or email
fax: (310) 796-9054
email: info@cbmalagains.com

4. Licensing Information

A. List all states in which you are or have been licensed, including license number and renewal date.

State License Number Renewal Date

B. Are you a member of any professional organization? Yes No
 If yes, please give details.

5. Professional Liability Insurance History

Name of Company (Current)	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
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Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence

A. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage? Yes No
 If yes, requested retroactive date _____

Important: If you are not applying for prior acts coverage and are not purchasing a reporting endorsement from your current carrier, please explain why on a separate sheet.

B. Have you changed your field or scope of practice or modified your specialty during the past three years? Yes No
 If yes, explain: _____

C. Have you changed the address of your practice during the past three years? Yes No
 If yes, list prior addresses:

D. Has any insurance company (including Lloyds of London) ever canceled, declined to issue or refused to renew your insurance or offered Professional Liability Insurance only on special terms? Yes No

- F. Have you ever:
- i. been charged with, pled guilty to, or convicted of a criminal offense? Yes No
 - ii. been treated for (or recommended for treatment of) alcoholism, sexual addiction, anger management or drug addiction? Yes No
 - iii. undergone or been recommended to undergo psychiatric treatment?..... Yes No
 - iv. had a complaint filed against you with any hospital, professional society or regulatory board? Yes No
 - v. had any professional license/permit or narcotics license investigated, suspended, revoked, restricted or placed under probation? Yes No
 - vi. failed a licensing, specialty or board certification exam? Yes No

If you answer yes, to question(s) 5C, 5D, 5E, or any part of 5F, please provide complete details on a separate sheet of paper.

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

- H. Has any action been filed against you or have you been notified that any action, regardless of dollar amount, will be filed against you alleging professional errors or omissions? Yes No
 If available, please enclose a copy of complaint.

If you answer yes, to question(s) 5G, or 5H, please complete the attached Supplementary Claims Information Form on page 8.

6. Rating Information

A. Profession:

- | | | |
|---|---|---|
| <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Certified Nurse Practitioner |
| <input type="checkbox"/> Surgeon's Assistant | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Certified Registered Nurse Anesthetist |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Cytotechnologist | <input type="checkbox"/> Emergency Medical Tech |
| <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Radiology Tech | <input type="checkbox"/> Radiation Tech |
| <input type="checkbox"/> Occupational Tech | <input type="checkbox"/> Respiratory Tech | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> RN/LPN | <input type="checkbox"/> Phlebotomist | <input type="checkbox"/> Certified Nurse Midwife |
| <input type="checkbox"/> Other (explain): _____ | | |

- B. Do you moonlight (work outside control of the above employer)? Yes No
 If yes, where?

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

- D. 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

- E. Do you elicit, evaluate and record the health, psychosocial and developmental history of the patient? Yes No

- F. Do you order or perform diagnostic tests? Yes No

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

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

I. Do you perform a physical examination? Yes No
If yes, briefly describe techniques and instruments used.

J. Do you conduct informed consent discussions? Yes No

K. Do you assist in surgery? Yes No

L. Do you administer anesthesia? Yes No

M. Do you perform normal deliveries? Yes No

N. Describe any other procedures, treatments, or duties you perform.

O. If applicable, describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice.

P. Are you employed by, or are you an independent contractor for, physicians or dentists? Yes No
If yes, list all physician and dentist names, where they are insured, limits of liability and policy expiration dates:

Name	Insurer	Limits	Policy Expiration
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8. Educational Information

Name and Type of Graduate and Post Graduate School(s) Attended	Location	Degree	Date Graduated

A. Do you have any other specialized training? Yes No
If yes, give details _____

B. Do you hold the certification or licensure required in your state to practice your profession? Yes No

IMPORTANT! YOU MUST READ CAREFULLY

GENERAL FRAUD WARNING

Any person who knowingly includes any false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.

NEW JERSEY FRAUD WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PENNSYLVANIA FRAUD WARNING: 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 person to criminal and civil penalties.

WISCONSIN EXCEPTION: If the company agrees to be bound under the terms of this application, your policy will be canceled if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application.

Specific Consent to Conditions of Consideration of the Application for Insurance

With the submission of this application for insurance, 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 that may be issued to me:

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

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant who makes application for insurance and that my application will be evaluated by authorized personnel. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

Applicant's Signature

Date

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 page of this Application is an **Authorization to Release Information** form which requires your signature. Please read carefully.

Allied Health Professional Supplementary Claims Information Form

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: _____
2. Date reported to insurance company: _____
3. Name of insurance company: _____
4. Date of incident and your treatment: _____
5. Allegations: _____

6. What is the present condition of the patient? _____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim?
..... Yes No

8. Status of claim (check applicable answer):

<input type="checkbox"/> Suit threatened, no action taken <input type="checkbox"/> Suit filed but dropped by claimant <input type="checkbox"/> Summary judgment in your favor <input type="checkbox"/> Suit settled out of court a. Date claim paid: _____ b. Amount paid: \$ _____ c. Did <u>you</u> want to settle this claim?Yes <input type="checkbox"/> No <input type="checkbox"/>	<p>Court outcome in your favor:</p> <input type="checkbox"/> Jury verdict <input type="checkbox"/> Directed verdict <p>Court outcome in favor of plaintiff:</p> <input type="checkbox"/> Jury verdict <input type="checkbox"/> Directed verdict <p>Amt. of Loss Payment:</p> <p>\$ _____</p>	<input type="checkbox"/> Awaiting mediation <input type="checkbox"/> Awaiting court action <p>Reserve Amount:</p> <p>\$ _____</p>
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9. Name and address of the attorney assigned to your case: _____

10. To your knowledge, was any settlement paid by another party involved (i.e., your corporation, employer, partners, employees, etc.)?
..... Yes No

If yes, amount paid: \$ _____

Signature: _____ Date: _____

Name (Printed): _____