



**ALLIED PERSONNEL PROFESSIONAL LIABILITY INSURANCE APPLICATION**

**Instructions:** All questions must be answered. Please type or print clearly. No coverage is in place until application is approved and premium paid. All requested explanations and documents must be attached including: current declarations page, CV & currently valued loss runs.

**NOTICE**  
This is an application for  
Shared-Limits Coverage under a  
CLAIMS-MADE POLICY

1. (a) Applicant's Full Name: \_\_\_\_\_  
Other Name Used: \_\_\_\_\_

(b) Social Security #: \_\_\_\_\_ (c) Federal DEA #: \_\_\_\_\_

(d) Home Address: \_\_\_\_\_  
Number Street City County State Zip

(e) Principal Office: \_\_\_\_\_  
Number Street City County State Zip

(f) Other Office Address(es): \_\_\_\_\_  
(if any) Number Street City County State Zip

Degree/Title: \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Male  Female   
Phone: (\_\_\_\_) \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Fax: (\_\_\_\_) \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_

2. Specify States where you are licensed:

_____ (License #) (State of Licensure) (Field)	_____ (License #) (State of Licensure) (Field)	_____ (License #) (State of Licensure) (Field)
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3. This is an application for:

Certified Nurse Midwife     Certified Registered Nurse Anesthetist     Nurse Practitioner  
 Physician's Assistant     Aesthetician     Other \_\_\_\_\_

4. School: \_\_\_\_\_ City State Country Degree Dates: \_\_\_\_\_  
mm/dd/yy to mm/dd/yy

5. List any additional training:

<u>Location</u>	<u>Type</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. If my application is approved, make coverage effective on \_\_\_\_\_, if possible, otherwise on any other date set by the Company.

7. (a) Name of Employer or Entity you Contract with: \_\_\_\_\_  
(b) Supervising Physician, if any: \_\_\_\_\_

8. Do you have an employment contract? YES  NO   
If YES, do you:  Observe  Assist  Other (explain) \_\_\_\_\_

9. Does your employment/practice require you to practice in an operating room? YES  NO

If YES, do you:  Observe  Assist  Other (explain) \_\_\_\_\_

If YES, do you provide any services for any Genital Cosmetic procedures or Bariatric Surgery procedures? YES  NO

Please provide a brief description of your general duties: \_\_\_\_\_

10. Does your employment/practice require you to practice in a labor and delivery room or birthing center? YES  NO

If YES, do you perform duties under direct physician supervision? YES  NO

Please provide a brief description of your general duties: \_\_\_\_\_

11. List all locations where you have practiced in the last 10 years. Explain any gaps in your practice.

	<u>Group Name</u>	<u>Street</u>	<u>City</u>	<u>County</u>	<u>State</u>	<u>During Years</u>
(a)	_____					
(b)	_____					
(c)	_____					
(d)	_____					

12. List malpractice coverage for the past 10 years, beginning with your current or most recent carrier:

Name of Insurer	Dates Covered From – To (MM/DD/YY)	Limits of Liability	Retro-active Date	Coverage Type (Occurrence or Claims-Made)	Premium	Was Tail Coverage Purchased?	# of Pending Claims	# of Closed Claims	Total # of Claims
<b>A</b>									
<b>B</b>									
<b>C</b>									
<b>D</b>									

1. PLEASE ATTACH A COPY OF YOUR MOST RECENT DECLARATION'S PAGE AND POLICY.

2. PLEASE FILL OUT A CLAIM INFORMATION FORM FOR EACH SUIT, CLAIM, LETTER OF INTENT AND INCIDENT, OPEN OR CLOSED, AND SUBMIT ANY ADDITIONAL INFORMATION RELATIVE TO THESE CLAIMS.

(a) Do you intend to purchase a reporting endorsement (a.k.a. Tail Coverage) from your current insurer? YES  NO

(b) If answer to (a) is NO, do you wish to obtain Prior Acts Coverage from us? **NOTE: The offering of Prior Acts Coverage is subject to Underwriter approval.** YES  NO

(c) If answer to (b) is YES, please attach a copy of your present insurance policy, with all endorsements, and complete the following:

Applicant is/is not (**circle one**) as of this date aware of any Claims, Suits, Letters of Intent, Records Requests or Incidents that have not been reported to his/her (**circle one**) present or prior insurer(s). Please Initial: \_\_\_\_\_

**NOTE: If you do not purchase Prior Acts Coverage from us you will not have any coverage through us for any claim or suit based upon the rendering of or failure to render professional services prior to the effective date of your policy, if issued. We strongly urge you to consult your broker to discuss continuity of coverage and the implications thereof.**



## NO KNOWN CLAIMS DECLARATION

I declare that I am not aware of, nor do I, or any agent, employee, representative, or any other person(s) serving or acting on my behalf have any knowledge of, any claim, notice of claim, records request, letter of intent, incident, any unreported conduct, or any circumstance or occurrence which could reasonably be expected to result in a claim against me subsequent to the date of my signature below that I have not already reported to my previous professional liability carrier and which I have not disclosed on my application to Professional Underwriters Liability Insurance Company.

I have reported all claims, and all facts or circumstances that could give rise to a claim to appropriate prior carrier(s) and understand that all such known claims or potential claims will not be covered by this insurance. I also understand that this insurance does not apply to any of the following:

1. Any incident or claim for which I have received notice of a claim.
2. Any incident or claim for which a legal action has been filed against my employees or me.
3. Any incident or claim upon which any companies previously insuring me have previously established a claim file.
4. Any incident or claim arising out of any fact, circumstance, or situation indicating the possibility of a claim which was known to me as of the effective date of insurance for which I am applying.

Signature:  \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Print Name

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## WARRANTY & RELEASE

I do hereby warrant the truth of all statements and answers mentioned herein, and that I have not withheld any information which may influence or would influence the judgement of the Company in considering this application for professional liability insurance.

I understand that if the information in this application materially changes between the date of this application and the policy effective date, I will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

I understand and agree that erroneous and/or material misrepresentations or omissions will cause immediate rescission of my insurance coverage.

I understand and agree that the Company will not provide defense or indemnity coverage for any claims, civil lawsuits, arbitration, legal or administrative proceedings, incidents, accidents, or events in which damages or liability is assumed or imposed, or sought to be imposed, upon an insured under a written or oral agreement, specifically including a "hold harmless" indemnification or similar agreement, where the damages or liability assumed by, imposed or sought to be imposed are greater than that which would exist in the absence of such an agreement.

This application form, duly completed, together with any supplementary information, **must** be signed and dated in ink by the applicant. Signature of the form does not bind the applicant or the Company to issue coverage.

I understand that in order to underwrite professional liability insurance, the Company must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, preceptorship, residency program, insurance company, underwriter and insurance agent/broker to furnish any information concerning me or my medical practice which the Company or its representative may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Company pursuant to this consent and direction, together with the agents, employees or officers of such person or organization will not be liable to me in any way for furnishing such information, even if the information is wrong.

Signature:  \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# CLAIMS INFORMATION FORM

## CLAIM INFORMATION - Please type or print clearly

1. Name of Patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_ 3. Sex: \_\_\_\_\_

4. Your relationship to patient: \_\_\_\_\_  
\_\_\_\_\_

5. Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Date of Incident: \_\_\_\_\_ 7. Date Reported to Carrier: \_\_\_\_\_ 8. Location: \_\_\_\_\_

9. Insurance Carrier(s): \_\_\_\_\_

10. Other Defendants: \_\_\_\_\_

11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES  NO

12. Present Status: \_\_\_\_\_ Incident Only \_\_\_\_\_ Pending Suit \_\_\_\_\_ Closed

Date Closed: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Settlement or Judgment (circle one)

13. Condition and diagnosis at time of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Defense Counsel: \_\_\_\_\_

17. Plaintiff's Counsel: \_\_\_\_\_

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**CLAIMS INFORMATION FORM**  
**(Please make additional copies if needed)**

**CLAIM INFORMATION - Please type or print clearly**

1. Name of Patient: \_\_\_\_\_ 2. Age: \_\_\_\_\_ 3. Sex: \_\_\_\_\_

4. Your relationship to patient: \_\_\_\_\_  
\_\_\_\_\_

5. Allegation(s) (as stated by patient/plaintiff): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Date of Incident: \_\_\_\_\_ 7. Date Reported to Carrier: \_\_\_\_\_ 8. Location: \_\_\_\_\_

9. Insurance Carrier(s): \_\_\_\_\_

10. Other Defendants: \_\_\_\_\_

11. Did you, or was it alleged that you, modified, destroyed or changed any medical records related to this claim? YES  NO

12. Present Status: \_\_\_\_\_ Incident Only \_\_\_\_\_ Pending Suit \_\_\_\_\_ Closed

Date Closed: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Settlement or Judgment (circle one)

13. Condition and diagnosis at time of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Dates and description of treatment rendered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Condition of patient subsequent to treatment (include DATES & FOLLOW-UP TREATMENT): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Defense Counsel: \_\_\_\_\_

17. Plaintiff's Counsel: \_\_\_\_\_

**I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

Signature: **X** \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## NOTICE:

The underwriter is authorized to make any inquiry in connection with this application. The underwriter's acceptance of this application or the making of any subsequent inquiry does not bind the applicant or the underwriter to complete the insurance or issue a policy.

If the information in this application materially changes between the date of this application and the policy effective date, the applicant will immediately notify the underwriter, and the underwriter may modify or withdraw any premium quotation or agreement to bind insurance.

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**Colorado Applicants:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**District of Columbia Applicants:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**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.

**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, which is a crime.

**Louisiana Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**Missouri Applicants:** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question of this nature appears in this application, you should not respond.

**New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New Mexico Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines civil and criminal penalties.

**Ohio Applicants:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Applicants:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**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 person to criminal and civil penalties.

**Tennessee Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Virginia Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

**West Virginia Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.