PROASSURANCE
Treated Fairly

Allied Health Professional Liability Insurance Application Form

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.*

ProAssurance Casualty Company
P.O. Box 150
Okemos, MI 48805-0150
800.282.6242 • 608.828.1100 (Fax)

For Agent's Use Only (if applicable)

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone

Note: If any space provided herein is insufficient for complete reply, please use a separate sheet, identifying by number the questions you answer.

1. Personal Information

A. Name: _____
FIRST MIDDLE LAST

B. Date of Birth: _____ C. Social Security Number: _____

D. Home Address: _____

City: _____ State: _____ ZIP: _____

E. Home Phone: _____ F. Email Address: _____

2. Office Information

A. Current Employer: _____

B. Business Address: _____

City: _____ State: _____ ZIP: _____

C. Office Phone: _____ D. Office Fax: _____

E. Preferred Billing Address: ☐ Employer's Office ☐ Business Address ☐ Home

F. Is your employer insured by a ProAssurance Company? Yes ☐ No ☐

3. Coverage Selection

Requested Effective Date: _____/_____/_____
MONTH DAY YEAR

A. Primary Coverage Limits: Indicate your desired level of primary coverage by placing an "X" in the appropriate box.

Illinois	Michigan	New Jersey
☐ $250,000/$750,000	☐ $100,000/$300,000	☐ $1,000,000/$3,000,000
☐ $500,000/$1,500,000	☐ $200,000/$600,000	
☐ $1,000,000/$3,000,000	☐ $250,000/$750,000	
	☐ $300,000/$900,000	
	☐ $500,000/$1,000,000	
	☐ $1,000,000/$3,000,000	

Coverage will become effective only after the completion of all underwriting functions and acceptance by the company.

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:	☐ Claims-Made ☐ Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	☐ Claims-Made ☐ Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	☐ Claims-Made ☐ Occurrence
Name of Company	Policy Limits	Period of Coverage: Retroactive Date:	☐ Claims-Made ☐ Occurrence

A. Have you ever applied to a ProAssurance company for insurance before? Yes ☐ No ☐

B. 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.

C. Have you changed your field or scope of practice or modified your specialty during the past three years? Yes ☐ No ☐

If yes, please explain: _____

_____

D. Have you changed the address of your practice during the past three years? Yes ☐ No ☐

If yes, list prior addresses: _____

_____

E. Has an insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? 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.

6. Rating Information

A. Profession:

☐ Physician Assistant	☐ Perfusionist	☐ Certified Nurse Practitioner
☐ Surgical 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

☐ 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

7. 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, please give details: _____

_____

_____

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

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

Consent to Conditions of Consideration of the 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 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.

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 coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Authorization to Release Information

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 as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

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 photo copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

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

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):

☐ Suit threatened, no action taken	☐ Court outcome in your favor	☐ Awaiting mediation
☐ Suit filed, but dropped by claimant	☐ Jury verdict	☐ Awaiting court action
☐ Summary Judgment in your favor	☐ Directed verdict	Reserve Amount: _____
☐ Suit settled Out-of-Court	☐ Court outcome in favor of plaintiff	
Date claim paid: _____	☐ Jury verdict	
Amount paid: _____	☐ Directed verdict	
Did you want to settle this claim? Yes ☐ No ☐	Amount of Loss: _____	

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 P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐
    If yes, amount was: $_____

Name (Printed): _____

Signature: _____ Date: _____