Limited Professional Liability Insurance
Application for Insured Paramedical Employees

ProAssurance Casualty Company • PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 205.414.2895

Requested Effective Date: _____ /_____ /_____ License/NPI Number: _____

Name (Last, First, MI): _____

SSN: _____ DOB: _____ Sex: Male ☐ Female ☐

Home Address: _____ City: _____ State: _____ ZIP: _____

Current Employer: _____ Telephone Number: _____

Business Address: _____ City: _____ State: _____ ZIP: _____

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	OTHER: _____

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

3. Have you ever:

   A. Been convicted of a criminal offense? Yes ☐ No ☐

   B. Been treated for (or recommended for treatment for) alcoholism, sexual, or drug addiction? Yes ☐ No ☐

   C. Undergone psychiatric treatment? 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 of paper.

4. Do you moonlight (work outside control of employer)? If yes, where? Yes ☐ No ☐

   _____

   _____

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

   _____

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

   _____

   _____

7. 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 yes, please give details on a separate sheet. If available, please enclose copy of complaint.

8. 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 yes, please give details on a separate sheet. If available, please enclose copy of complaint.

9. 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? *(This question not applicable in Missouri.)* Yes ☐ No ☐

10. 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.

11. 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 ☐

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

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

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

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

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

_____

17. Do you conduct informed consent discussions? Yes ☐ No ☐

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

_____

_____

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

_____

_____

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

State	License Number	Renewal Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

21. Please include copies of the following:
A. Current Curriculum Vitae
B. Copy of your approved notification of supervision form
C. Copy of current professional liability insurance declarations page
D. Claims history
E. Copies of your practice protocols

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 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: _____

Shared Limits Coverage ☐

Separate Limits Coverage ☐

Note: Separate Limits Coverage is not available for Cytotechnologists.

_____ _____

Signature of Insured Physician/Supervising Physician Date

_____

Please Print Name