

If NONE, please attach an explanation.

APPLICATION FOR PARAMEDICS, EMT'S, NURSE PRACTITIONERS, AMBULANCE SERVICES AND PHYSICIANS' AND SURGEONS' ASSISTANTS PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

- ${\bf 1.}\ Answer\ all\ questions.\ If\ the\ answer\ requires\ detail,\ please\ attach\ a\ separate\ sheet.$
 - 2. Application must be signed and dated by owner, partner or officer.

PART I - ALL APPLICANTS MUST COMPLETE:

AP	PLICA	ANT INFORMATION		
a.	(i) (ii)			Professional Degree Place of Birth:
b.	(i)	Principal business premise address:	(Street)	(County)
	(ii)	Other Business Locations:		
	(iii) (iv) (v)	Square feet of total office space (all loc Number of Employees: Full time Business Phone: ()	Part time	Total
c.	(i) (ii)	practice other than as an employee C Formal business, corporate or partners List the names of all partners or mem services:	hip name: obers of your professional assoc	iation/corporation who provide professional
d.		?	•	Accountability Act of 1996 (HIPAA) Privacy
	(i) (ii)	Has the Applicant implemented proceder Provide the name and title of the Applicant implemented proceder.	cant's Privacy Officer	
 ΔΡ		Business Associate Agreement is availal ANT PRACTICE	ble. This is the only Business Ass	sociate Agreement we will recognize.
 a.	Your	Practice: _ Solo Practitioner (unincorporated) _ Solo Practitioner (incorporated) _ Partnership _ Professional Association	Professional Corporation Professional Corporation Employee of	on (non-profit)
b.		Other (Describe)se list all states where you are licensed t		

U.	Plea	•						
	[]	Ambulance S	ervice	[] Nurse	Practitioner	[] Surgeon's Assistant		
	ίi	Emergency M	edical Technicia	n [] Param	edic	Other (specify)		
		Nurse Anesth			ian's Assistant			
d.	Plea	ise give the ap	proximate perce	ntages of time sp	ent in the following	g work locations:		
		% Administr	ative Office	% L	aboratory	% Hospital Ward (spe	cify)	
		% Ambulan	ce		Operating Room		• /	
		% Classroo	m		Outpatient Clinic	% Professional Office	(specify	
		% Emergen	cy Dept. of Hosp	ital% L	aboratory	profession)		
		% Nursing I	łome	% P	Patient's Home	% Other (specify)		
e.	Plea	se indicate the	e approximate di	vision of vour pati	ients or clients amo	ona:		
		nodialysis	%	Psychiatric	%	Bariatrics	%	
		stic Medicine		Drug Addicts	· · · · · · · · · · · · · · · · · · ·	Physical Rehabilitation	% %	
	Surg		%	Alcoholics	%	Disability Evaluation	%	
		ss Testing	%	Obstetrical	%	Research or Experimental	%	
		nmunicable	%	Dental	%			
	Fam	ily Planning	%	Pediatric	%		%	
							100%	
f.	Plea	se indicate the	e number and tvr	oe of vour employ	ees and/or volunte	ers. IF NONE, STATE NONE.		
			ncy Medical Tech		Physicians' As			
			nesthetists		Surgeons' Ass			
		Nurse Pi			Ourgeons 7to	olotanto		
		Paramed						
		r aramed	1100					
					g. Are all of the above individuals licensed in accordance with applicable state and federa			
g.		all of the abov	e individuals lice	nsed in accordan	ce with applicable	state and federal regulations?	[] Yes [] No	
g.	Are		e individuals lice h an explanation		ce with applicable	state and federal regulations?	[] Yes [] No	
	Are a	, please attac	h an explanation			-	[]Yes []No	
g. h.	Are a	, please attac	h an explanation	mounts of actual a	and projected total	revenue:		
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Ins	Insurance Carrier Number Liability (if any) Premium Mo./Day/Yr. Mo./Day/Yr. Made Portion Yes []	s a Claims plicy Form? No [] []
C.	c. If prior professional liability insurance was on a claims made basis, please indicate the retroactive e coverage.	[] exclusion date
Р	PERSONNEL	
a.	Please list the number and type of independent contractors who provide professional services on your b STATE NONE.	ehalf. IF NON
	Emergency Medical Technicians Physicians' Assistants	
	Nurse Anesthetists Surgeons' Assistants	
	Nurse Practitioners	
	Paramedics	
b.	b. Do you supervise any individuals who are not your own employees? If yes, please provide adetailed explanation of responsibilities and relationships to the entity which employs these individuals.	.[]Yes []N
C.	c. Please indicate by profession the number of individuals you supervise:	
	Number Type of Profession Number Type of Profession Number Type of Profession	ofession
	Emergency Medical Technicians Nurse Practitioners Surgeons'	Assistants
	Laboratory Technicians Nurses, Registered	
	Nurse Anesthetists Paramedics	
	Nurses, Licensed Practical Physicians' Assistants	
AF	APPLICANT PROCEDURES	
a.	a. Do you render professional services directly to patients?	.[]Yes []N
	If yes, please describe these services in detail and indicate whether you are supervised and by whom.	
	Percent of Time <u>Detailed Description of Professional Services</u> <u>Supervised</u> <u>Title of Supervisor</u>	
	%	
	%	
	%	
b.	b. Do you render professional services that do not involve contact with a patient?	[] 20V []
IJ.	If yes, please describe these services in detail.	
	ii yes, piease describe triese services iii detaii.	
C.	c. Do you administer any anesthesia?	

		(ii)	Please list ALL surgical procedures performed (including minor surgery):		
		(iii)	Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others?]Yes [] No
		(iv)	Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility?[If yes, please attach a detailed explanation.]Yes [] No
	e.	(i)	Do you perform radiation therapy?] Yes [] No
		(ii)	Psychiatric shock therapy?[] Yes [] No
	f.		ou prescribe or dispense any drugs without the countersignature of a physician?[s, please provide a detailed explanation.] Yes [] No
6	ΔΡ	PLIC	ANT AFFILIATIONS		
<u></u>		Are	you associated with or do you work for a physician or surgeon?] Yes [] No
	b.	-	you own or operate any business other than that shown in Question 1(a) above?[s, please attach an explanation, including details of your responsibilities.] Yes [] No
	C.		you employed by an individual other than that shown in Question 1(a) above?[] Yes [] No s, please attach an explanation, including details of your responsibilities.		
	d.	If ye	you under contract to any individual or entity other than that shown in Question 1(a) above?[s, please attach an explanation, including details of your responsibilities. If this contract ains a hold-harmless agreement, please attach a copy of the contract.]Yes [] No
	e.		you employed by or under contract to any governmental entity?] Yes [] No
	f.		you under contract to any governmental entity?[s, please attach an explanation, including details of your responsibilities.] Yes [] No
	g.		you advertise your professional services in any manner (other than a simple listing in a] Yes [] No
	h.		you associated with any agency or organization that engages in advertising for, or solicitation[eatients? If yes, please attach a detailed explanation and a copy of ALL relevant advertisements.] Yes [] No
7.	CL	AIMS	3		
	a.		any claim or suit been brought against you and/or any of your employees?[s, please complete a supplemental claim information form for each claim or suit.] Yes [] No
	b.		you aware of any circumstances which may result in a malpractice claim or suit being made or[Ight against you or any of your employees? If yes, please provide details on a separate sheet.] Yes [] No
8.	PR	OFES	SSIONAL SOCIETIES		
	a.	Plea	se indicate membership in professional societies or associations:		

PART II - INDIVIDUAL APPLICANTS ONLY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

	CI	CITIZENSHIP							
	a.	Are you a U.S. citizen? If no, please indicate	cate your status a	nd date of entry in	to the U.S.A [] Yes [] No				
2.	ED	EDUCATION							
	a.	Describe your professional training:							
		Institution (Name & Address)	Yea	rs of Training	Degree or Certification Attained				
			From	To					
			<u></u>						
			From	To					
3.	EX	PERIENCE							
	Wh	ere have you practiced your profession d	uring the last ten	/ears:					
		Prior Experience - From:	· ·		Location:				
		Practice Activity:							
	b.	Prior Experience - From:			Location:				
		Practice Activity:							
	C.	Prior Experience - From:	To:	I	Location:				
		Practice Activity:							
	d.	Practice Activity: Have you ever failed any professional lic If yes, please attach a detailed explanati	ensing or specialt	y organization exa	mination? [] Yes [] No				
PA TH	RT RAM E AD	Have you ever failed any professional lic If yes, please attach a detailed explanati III - PLEASE ANSWER THE FOLLOWING JEDICS OR EMERGENCY MEDICAL TECHNI OMINISTRATOR OR BUSINESS MANAGER,	ensing or specialt on, including date QUESTIONS ONL ICIANS AND/OR TH	y organization exa s and location. Y IF A QUOTATION IE EMPLOYER. TH	ON IS REQUESTED TO COVER A GROUP OF JESE QUESTIONS ARE TO BE COMPLETED BY				
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* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evid acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insure underwriting manager, Company and/or affiliates thereof.					
Name of Applicant	Title (Officer, partner, etc.)				
Signature of Applicant	 Date				

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.