Allied Healthcare Individual Provider Medical PL HPSI Agency App™

1. PERSONAL DATA

Name: First ____ Middle Initial ____ Last ____

Please indicate your professional specialty (CHECK ONE):

☐ Aesthetician	☐ EMT - Paramedic	☐ NP - Nurse Practitioner	☐ Pharmacist
☐ Audiologist	☐ Electrologist	☐ Nutritionist	☐ Phlebotomist
☐ Ambulance Attendant	☐ Hypnotist - Hypnotherapist	☐ Ocularist	☐ Psychologist
☐ Case Management	☐ LPN - Licensed Practical Nurse	☐ Optometrist or Optician	☐ RN - Registered Nurse
☐ Certified Medical Assistant	☐ Licensed Clinical Social Worker	☐ Orthotist	☐ Surgical Technician
☐ Diagnostician	☐ Nutrionist	☐ Pathologist	☐ Vascular Technologist
☐ Dietician	☐ Masseur - Masseuse	☐ Perfusionist	

☐ Counselor (Describe) ____ ☐ Therapist (Describe) ____

☐ Technician (Describe) ____ ☐ Other (Describe) ____

☐ CNMW - Midwife (Please also complete the attached 1 page CNMW Supplement in addition to this application)

☐ PA - Physician Assistant (Please also complete the attached 1 page PA Supplement in addition to this application)

Date of Birth: ____ Social Security No: ____ Gender: ☐ Male ☐ Female

Are you a U.S. citizen? ☐ Yes ☐ No If no, what is your status in the U.S.? ____

2. EDUCATION AND TRAINING

Name and Location of Medical School: ____

Degree/Certification Attained: ____ Year Graduated: ____

List States in which you are actively licensed and requesting coverage for: ____

3. INSURANCE COVERAGE LIMITS REQUESTED

Requested Effective Date: ____ Prior Acts Date (Retroactive Date): ____

Requested Limits:

☐ $100,000/$300,000	☐ $500,000/$1,500,000	☐ $1,300,000/$3,900,000 **(NY Only)**
☐ $200,000/$600,000	☐ $1,000,000/$3,000,000	☐ $2,000,000/$6,000,000 **(VA Only)**
☐ $250,000/$750,000	☐ $1,000,000/$6,000,000	

4. PRACTICE INFORMATION

Regarding the practice work that you are requesting coverage for - does it involve any of the following?

Does the practice involve the treatment of nursing home residents? ☐ Yes ☐ No If "Yes" ____ %

Does the practice involve the treatment of prison inmates? ☐ Yes ☐ No If "Yes" ____ %

Does the practice involve the treatment of Emergency Department? ☐ Yes ☐ No If "Yes" ____ %

Does the practice operate as a MedSpa of perform Cosmetic procedures? ☐ Yes ☐ No If "Yes" ____ %

Does your state medical board require a written Collaborative Agreement between yourself and your supervision physician?

☐ Yes ☐ No ☐ N/A If "Yes" is said written agreement in place? ☐ Yes ☐ No

The practice for which coverage is being request is:

A. My Primary Full-Time or Primary Part-Time Practice ☐

If the practice work for which you seek coverage is Secondary Part-Time and/or "Moonlighting opportunity please attach a current Certificate of Insurance evidencing that you have Professional Liability Insurance for you primary practice.

Who do you primarily work for?

Regarding your primary practice work - are you an Employee (i.e. paid by W2)? ☐ Yes ☐ No

- or are you an Independent Contractor (i.e. paid by 1099)? ☐ Yes ☐ No

Primary practice - Average number of hours worked per week: Average number of patients seen per week:

Primary Practice Address: Office Phone:

City State County Zip Code

B. My Secondary Part-Time Practice ☐

Regarding your secondary practice work - are you an Employee (i.e. paid by W2)? ☐ Yes ☐ No

- or are you an Independent Contractor (i.e. paid by 1099)? ☐ Yes ☐ No

Secondary practice - Average number of hours worked per week: Average number of patients seen per week:

Secondary Practice Address: Office Phone:

City State County Zip Code

C. "Moonlighting" and/or Fill in Work ☐

Regarding your Moonlighting practice work - are you an Employee (i.e. paid by W2)? ☐ Yes ☐ No

- or are you an Independent Contractor (i.e. paid by 1099)? ☐ Yes ☐ No

Moonlighting practice - Average number of hours worked per week: Average number of patients seen per week:

Moonlighting Practice Address: Office Phone:

City State County Zip Code

NOTE: If requesting coverage for a secondary part-time practice, moonlighting or fill-in work please provide details below regarding the type medical practice you will be working for (i.e. Clinic, General Practice, Hospital, etc):

5. INSURANCE HISTORY

1. Current Carier: [ ] ☐ Claims-Made ☐ Occurrence

   Effective Date: [ ] Expiration Date: [ ] Retroactive Date: [ ]

   Limits of Insurance: [ ] Per Claim/ [ ] Aggregate

   Current Annual Premium: [ ]

2. *If* you are currently insured on a claims-made policy, are you obtaining Extended Reporting Period (tail) from your current insurance carrier? ☐ Yes ☐ No ☐ N/A (have occurrence coverage now)

   Note: To prevent possible gabs in your claim-made coverage, you much either purchase Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from your new Insurance Company.

   Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.

3. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization). If your attached CV provides the same information, you may go on to the next section. ☐ CV attached

   City/State: [ ] From: [ ] To: [ ]

   ☐ Solo Practitioner ☐ Part of a group Group Name: [ ]

   City/State: [ ] From: [ ] To: [ ]

   ☐ Solo Practitioner ☐ Part of a group Group Name: [ ]

   City/State: [ ] From: [ ] To: [ ]

   ☐ Solo Practitioner ☐ Part of a group Group Name: [ ]

6. UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

Within the past 10 years:

1.	Have you been convicted of a misdemeanor (other than traffic related) or felony or is any such charge pending?	☐ Yes	☐ No
2.	Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program? If yes, please provide an explanation on a separate sheet of paper.	☐ Yes	☐ No
3.	Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis? If yes, provide an explanation on a separate sheet of paper.	☐ Yes	☐ No
4.	Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility? If yes, please provide an explanation on a separate sheet of paper.	☐ Yes	☐ No
5.	Have you every resigned from a health care facility while under investigation or to avoid possible disciplinary action?	☐ Yes	☐ No
6.	Has an hospital, as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision?	☐ Yes	☐ No
7.	Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or health care facility at which you practice(d)?	☐ Yes	☐ No
8.	Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	☐ Yes	☐ No
9.	Have you provided any care that resulted in a formal incident report or investigation by any healthcare facility?	☐ Yes	☐ No
10.	Have Medicare or Medicaid authorities ever investigated or brought charges against you?	☐ Yes	☐ No

11.	Have you provided any professional services without professional liability insurance?	☐ Yes	☐ No
12.	Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	☐ Yes	☐ No
13.	Have you ever treated any patients by means of unconventional therapeutics, or have you utilized non-FDA approved experimental drugs other than through Institutional Review Board (IRB) approved research programs?	☐ Yes	☐ No

7. CLAIMS INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

Within the past 10 years:

1.	Have you been involved in a malpractice claim, lawsuit, incident or occurrence in the last 10 years?	☐ Yes	☐ No
	If "Yes" then how many?		
2.	Are you aware of any circumstances that may result in a malpractice claim or suit being made or being brought against you?	☐ Yes	☐ No
3.	Are you aware of any outstanding incidents, claims, or suits (even if you believe the outstanding claim or suit would be without merit) that have not been reported to your current or prior professional liability carrier?	☐ Yes	☐ No
4.	Have you been contacted by a plaintiff's attorney or required to produce medical records or statements regarding any case you have been involved with, and you have not been specifically named in the suit or claim?	☐ Yes	☐ No

ADDITIONAL COMMENTS

I have answered the question in the Application to the best of my ability and declare that , to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application shall be the basis of the contract should a policy be issued. I agree to notify the Company of any change in my practice of medicine no less than (10) days of its occurrence:

Signature	Print Name	Date

ALL QUESTINS MUST BE ANSWERED AND THE APPLLICATINO MUST BE SIGNED AND DATED

(PA) Physician's Assistant Supplement

Please indicate your Physician Assistant Rating Class:

☐ **CLASS P1**:

A physician assistant who carries out responsibilities generally performed by a qualified licensed physician and who practices under the direction and supervision of a licensed physician to assist the physician in the diagnosis and treatment of patients. A physician assistant with any exposure to an operating room for **Observation Only.**

☐ **CLASS P2:** A physician assistant who practices any of the following:

1. Assisting a licensed physician who is qualified to perform surgery **-** any practice exposure in an operating room other than for observation with a general practitioner/family practice or general surgeon;
2. Practicing or exposure (10 hours a week or less) to trauma/emergency room procedures or responsibilities;
3. Assisting a qualified licensed physician in Anesthesiology.

☐ **CLASS P3:** A physician assistant who is involved in any of the following:

1. Assisting an Orthopedic surgeon, OB/GYN surgeon, cardiovascular surgeon and/or plastic surgeon in surgery in an operating room other than for observation;
2. Practicing or any exposure (more than 10 hours per week) in trauma/emergency room procedures or responsibilities;
3. Contact or exposure with Obstetrics including delivery room responsibilities;
4. Contact or exposure with cardiac catherization labs;
5. Assisting in Cosmetic/Aesthetic procedures.

☐ **CLASS PS:**

Students currently enrolled and attending a American Academy of Physician Assistants approved physician Assistants approved physician assistant program.

Are you a member of a Professional Association(s)? ☐ Yes ☐ No If "Yes" please list membership affiliations:

Have you completed the AAPA approved risk management course? ☐ Yes ☐ No

If "Yes" please attach a copy of the certificate to your application as proof of completion.

Signature	Print Name	Date

(CNMW) Certified Nurse Midwife Supplement

1. Total number of annual deliveries:
2. Do you perform only uncomplicated vaginal deliveries? ☐ Yes ☐ No

   If "No" please explain:

3. Do you assist in c-sections? ☐ Yes ☐ No

   If "Yes" how many do you assist in annually?

4. Do you perform any home births? ☐ Yes ☐ No

   If "Yes" provide details:

5. Do you work with a supervising obsterician? ☐ Yes ☐ No

   If "Yes" please provide name of your supervising M.D. or D.O.:

   Is this physician readily available in case of an emergency? ☐ Yes ☐ No

6. Name of the facility where you practice:

   Is the above facility a free standing birth center? ☐ Yes ☐ No

   Is the above facility either JCAHO and/or National Association of Childbirth Centers accredited? ☐ Yes ☐ No

   In miles, how near is the facility to the closest hospital?

   Is there a formal transfer agreement in place between the facility and the hospital pertaining to the potential admission to the hospital of your facility's patients? ☐ Yes ☐ No

7. Do you provide post natal infant care? ☐ Yes ☐ No

   If "Yes" provide details:

8. Do you perform circumcisions? ☐ Yes ☐ No

   If "Yes" how many do you perform per month?

9. Are you a member of a Professional Association(s)? ☐ Yes ☐ No

   Specify the Association(s):

10. Are you certified by an approved specialty board? ☐ Yes ☐ No

    Specify and provide certificate:

11. Have you participated in any CEU programs within the last 3 years? ☐ Yes ☐ No

    Specify and provide certificate of completion:

PLEASE ATTACH THE FOLLOWING: Copy of patient selection and referral Protocol under which the Applicant practices

Signature	Print Name	Date

Supplement Claim Information Form

(make copies of this page as needed)

1. Name of patient: ____ Age ____ ☐ Male ☐ Female
2. Describe the allegation made by claimant: ____
3. Date claim was made or filed: ____
4. Date of alleged incident: ____
5. Insurance company: ____
6. Additional defendants: ____
7. Disposition of claim? ☐ Open ☐ Closed

If open:

Claimant's settlement demand: $ ____

Defendant's offer for settlement: $ ____

Insurer's loss reserve: $ ____

Deductible amount: $ ____

Is claim in suit? ☐ Yes ☐ No   If "Yes" amount asked in summons: $ ____

If closed:

Date closed: ____ ☐ Court judgment ☐ Out of court settlement ☐ Dismissed with prejudice ☐ Dismissed without prejudice

Total indemnity paid (including deductible): $ ____

Total defense cost/expenses paid: $ ____

Total costs incurred: $ ____

Provide complete and detained information for evaluation. Use reverse side or additional sheets if required.

8. Condition and diagnosis at time of incidents (include date of visits)
9. Description of treatment rendered (include dates of visits)
10. Condition of patient subsequent to treatment (include dates of follow-up treatment)

Signature	Print Name	Date