POSITIVE PHYSICIANS INSURANCE EXCHANGE
850 CASSATT ROAD 100 BERWYN PARK SUITE 220
BERWYN, PA 19312
Phone: 888-335-5335 Fax: 610-644-5265

ALLIED HEALTHCARE PROFESSIONAL LIABILITY APPLICATION

Please print responses in ink, and answer all questions in full. If a question does not apply to your practice, state "none" or "N/A" (Not Applicable). Please indicate any additional responses on the Remarks Section, Page 3.
The complete application, together with any supplementary information, must be signed in ink and dated by the applicant in all spaces indicated. Failure to provide complete information will delay the processing of the application.

I. GENERAL INFORMATION

First Name   Middle Name   Last Name   Title

Date of Birth ______/______/______   Social Security Number: ______/_____/______

Requested effective date of coverage: ______/______/______   Retroactive Date: ____/_____/_____

This is an application for:

☐ CRNA   ☐ Nurse Practitioner   ☐ RN   ☐ Surgical assistant   ☐ LPN

☐ Surgical Technician   ☐ Physician's Assistant   ☐ Medical Assistant   ☐ Other

Type of Coverage requested:

____ Occurrence
_____ Claims Made Coverage without Prior Acts Coverage
_____ Claims Made Coverage with Prior Acts Coverage *****
*PPIX Claims Made Prior Acts Supplemental Application is necessary.

Medical Licenses: Specify states where you are or have been licensed.

State	Expiration	License #	Permanent	Temporary	Status

Limits Requested:

☐ $500,000 each medical incident / $1,500,000 annual aggregate

☐ $1,000,000 each medical incident / $3,000,000 annual aggregate

Primary Office Address and Information:

Please list all office locations where you currently practice. Use the Remarks Section to list additional locations at which you render professional services.

a) Street ____ Building/Suite _________________

City ____________________________ State __________ Zip Code _____________________

County ______________________ Number of years at this location______ % of practice _____

Primary Practice Office Phone   Fax

Primary Practice Office Phone	Fax
( )	( )

Practice Web Site Address: ____

E-mail Address: ____

List where have you practiced your profession for the past 10 years other than your current practice locations. Please explain any gaps in your practice. Use the Remarks Section to list additional locations. **Do not list training locations.**

Entity Name ____

Address ____

City ____________________ State __________ From _____/_____ to _____/_____
Mo. Yr. Mo. Yr.

Entity Name ____

Address ____

City ____________________ State __________ From _____/_____ to _____/_____
Mo. Yr. Mo. Yr.

II. MEDICAL TRAINING AND HISTORY *If CV is attached please skip questions #1 and 2.*

1. Education: Professional School

Name ____

City/State/Country ____

Degree ____________________
______________ Dates ____________________

2. Additional Training: If you have completed more than one internship or had further training, provide explanation in the Remarks section.

A) Internship-Clinical Rotation

Location ______________________ City/State ______________________

Date _____/_____/_____ to _____/_____/_____

III. PRACTICE INFORMATION

1. Does your employment require you to work in an operating room? ☐ Yes ☐ No

   If yes, please explain: ____

2. Does your employment require you to work in a labor and delivery room or birthing center? ☐ Yes ☐ No

   If yes, please explain: ____

3. Will you also carry professional liability insurance with another company? ☐ Yes ☐ No

   If yes, please answer the following:
   Practice description and location____

☐ Employee ☐ Independent Contractor Name of Carrier______________________

4. List the 5 most frequent surgical procedures you assist with: ____
____

5. List the 5 most frequent non-surgical procedures you assist with: ____________________________________
____

6. Are you entering practice for the first time since completing an internship?

☐ Yes ☐ No

7. Have you ever been reported to your professional licensing board or had an administrative hearing for a complaint filed against you? ☐ Yes ☐ No If yes, please explain: ______________________________________
____
____

8. Indicate your number of practice hours per week (include office hours, administrative activities, direct patient care, surgery, consultation, etc.). *Please indicate only the practice hours to be insured by PPIX.*

______________	______________	______________	______________
Average # of office hours per week	Average Patients per week	Average # of Hospital hours per week	Average # of Hospital admissions per year

List all facilities, including non-hospitals and ambulatory surgery centers, where you hold staff or courtesy privileges. List principle location first. Use the Remarks Section to list additional facilities and explain any restrictions.

Facility ____ City ________________ State __________

______% of practice Type: ____Full / Active ____Courtesy ____Consulting ____Restricted ____Other

Facility ____ City ________________ State __________

______% of practice Type: ____Full / Active ____Courtesy ____Consulting ____Restricted ____Other

Do you practice in any office surgical facility in which IV analgesia or general anesthetics are administered?

☐ Yes ☐ No If yes, list facilities: ____

If yes, is the office certified by JACHO or AAAHC?

☐ Yes ☐ No

If yes, please submit a copy of current certification.

REMARKS SECTION

If additional space is needed, please use your letterhead.

QUESTION NUMBER	ADDITIONAL REMARKS
________	____
________	____
________	____

IV. PROCEDURES **Please indicate with an X which you assist or perform.**

Scope of Practice: Check all that apply to your current professional practice

☐ In patient Facility Care	☐ Rehabilitation Treatment	☐ Family Planning Services
☐ Perform Physical Exams	☐ Compile Patient Histories	☐ Obstetric Care
☐ Health Education	☐ Long Term Care	☐ Assist in Surgical Procedures
☐ Pre/Post Op Procedures	☐ Psychiatric Care	☐ Assist in Administering Anesthesia
☐ Emergency Care	☐ HMO Gatekeeper	☐ Routine Lab Testing
☐ Specialist Referral	☐ Diagnostic Treatment	☐ Prescribe/Dispense Medication
☐ Perform Minor surgery	☐ Initiate Treatment Plans	☐ Critical Care
☐ Pediatric Care	☐ Patient Screening	

Work Setting: Please check all that apply

☐ Hospital In-Patient Unit	☐ School/Health Dept	☐ Hospital Operating Room
☐ Specialty Physician Office	☐ Hospice	☐ Correctional Facility
☐ Psychiatric Facility	☐ Outpatient Facility	☐ Nursing Home/LTC
☐ Walk-in Clinic	☐ Primary Physician Office	☐ Emergency Unit
☐ Trauma Center	☐ Surgi-Center	☐ HMO Facility
☐ Home Health Care		

V. INSURANCE CARRIERS

To assure that there are no gaps in coverage, please list all previous medical professional liability Insurance carried during the **past 10 years**, beginning with your current carrier. Use the Remarks Section, page 3, to list additional carriers.

Current Carrier ____

Policy Period ______/______/______ to ______/______/______ Limits of Liability _______________

Type of Policy _________________(occurrence or claims-made)

Retroactive Effective date, if applicable: ______/______/______

Attach a copy of the Declarations Page from your most recent policy.

First Prior Carrier ____

Policy Period ______/______/______ to ______/______/______ Limits of Liability _______________

Type of Policy ___________________ (occurrence or claims-made)

IF CURRENT COVERAGE IS CLAIMS MADE

If your current policy is claims-made and you cancel this policy without purchasing an extended reporting endorsement (tail coverage) from the current carrier, there will be no coverage for any claim from any act or omission that took place during that period of claims-made coverage.

However, you may apply for coverage with a retroactive date back to the first day of your claims-made policy.
A completed PPIX Claims Made Prior Acts Coverage Supplemental Application is necessary.

Retroactive coverage does not cover current claims that have been filed against you and/or reported to the previous insurer prior to the effective date of the policy with PPIX. Any claims and all conduct, circumstances, or incidents that could reasonable be expected to result in a claim must be reported to your present carrier prior to the requested effective date of this insurance.

VI. AUTHORIZATION

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgement of the company in considering this application for professional liability insurance. I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier. Erroneous information and/or material misrepresentation will cause immediate rescission of my insurance coverage.

AGREEMENT: I understand that the policy being applied for does not cover the liability of others that I may have assumed under any contract or agreement.
(Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed thereunder.)

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, inter-indemnity arrangement, underwriter, and insurance agent to furnish any information concerning me or my medical practice that the company may request.

AGREEMENT: Since I understand that the 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 agent, employees, or officers of such person or organization, will not be liable to me in any way for the furnishing such information.

AGREEMENT: I agree that in order to maintain insurance coverage I will comply with the Company's established risk management programs and requirements.

Upon acceptance by PPIX this Application will be made a part of any policy issued.

Commonwealth of Pennsylvania Fraudulent Insurance Acts: 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 in a crime and subjects such person to criminal and civil penalties.

Applicant (print): ____

Applicant Signature ___________________________ Date _________________

A competed application must include the following attachments:

_____ **Current and Prior carrier(s) loss history for 10 years, including open & closed claims**

_____ **Current CV** _____ **Current policy Declarations page**

ASSIGNMENT OF ANY RETURN PREMIUM

This section should be completed if the premium for this insurance is paid by someone other than the Applicant.

If the premium for this insurance has been paid and the policy is later cancelled or otherwise changed, any refund of premium that results from such cancellation or change should be assigned to:

Name of the Payor: ____
(employer or other person or entity to whom any refund check should be made payable)

The Payor agrees to pay any premium for the professional liability insurance policy applied for and any renewal or replacement of it. The Applicant for this insurance assigns any and all rights to receive any refund of premium in excess of that earned by Positive Physicians Insurance Exchange for this insurance to the Payor named above. The Applicant appoints Payor or Payor's successors or assigns as Applicant's Attorney-in-Fact with full authority to cancel or amend the insurance policy applied for and to execute or receive any document, instrument, payment or notice of any kind relating to the insurance policy, except with respect to giving or withholding consent to settle claim or suit as may be provided in the insurance policy applied for.

No other interest in the insurance applied for may be assigned by any party without the written consent of Positive Physicians Insurance Exchange.

This assignment will remain in effect unless both Payor and Applicant agr4ee in writing to its termination.

Applicant's Signature: ____ **Date:** _______________

TAIL COVERAGE

This section should be completed if the Applicant purchases a claims-made policy.

If the claims-made professional liability insurance policy is cancelled or non-renewed, the Applicant agrees that the following person or entity is designated as the responsible party for the purchase of a tail policy for the Applicant.

Name of Responsible Party: ____

Address of the Responsible Party: ____

____

Phone Number of the Responsible Party: ____

Fax Number of the Responsible Party: ____

The Applicant also agrees and understands that if a tail policy is not purchased upon cancellation or non-renewal of the policy, and prior-acts coverage is not purchased from their next carrier, the Applicant could be considered to be in non-compliance with licensure regulations.

Applicant's Signature: ____ **Date:** _______________

CLAIM INFORMATION FORM

Photocopy and complete this form for each open and/or closed claim for the past 10 years. If more space is needed on each report, continue information on your letterhead. Please write legible.

1) Name of Patient ________________________________ 2) Age _____________ 3) Sex_________

4) Relationship to patient

____

5) Other Defendants ____

6) Allegation ____

7) Date of Incident ______/______/______ 8) Report Date ______/______/______

9) Location ____

10) Insurance Carrier ____

11) Was a Suit ever filed? ___________ When?_____/_____/_____

12) Present Status ☐ Open Claim Loss of $ __________ ☐ Settlement

☐ Closed Claim Date Closed __________ ☐ Judgment

13) Condition and diagnosis at time of incident:

____

____

____

14) Dates and description of professional services rendered:

____

____

____

____

15) Condition of patient subsequent to professional services (and dates of follow-up visits) if known:

____

____

____

____

I hereby declare the above information is complete and true to the best of my knowledge and belief. I understand the information submitted herein becomes part of my application as submitted.

Signature ____ Date ____________________

PLEASE READ THE FOLLOWING BEFORE COMPLETING THE PRIOR ACTS APPLICATION!!!

Any item reported on the previous page must be reported to your current carrier prior to expiration of your present policy. Additionally, if you have received any requests for records from attorneys or from dissatisfied patients, or if you have received either verbal or written patient complaints about care rendered, these occurrences ***MUST*** be reported to your current carrier and recorded on the following page. If these matters are not reported to your current carrier, the chance of an uninsured claim is greatly increased!

____ Applicant Signature

____________ Date

POSITIVE PHYSICIANS INSURANCE EXCHANGE

SUPPLEMENTAL APPLICATION – CLAIMS MADE PRIOR ACTS COVERAGE

Name of Applicant

Requested Retroactive Effective Date:_____/_____/_____

ATTACH A COPY OF THE CURRENT DECLARATION PAGE SHOWING THE RETROACTIVE DATE

I hereby represent that I am requesting Claims Made coverage. Except as indicated below, I have no knowledge of any professional liability claims, circumstances, occurrence, incidents or conduct which has been or likely to be asserted against me or any corporation association or partnership for which I am making application, which occurred on or after the requested Retroactive Effective Date.

Report below any such incidents involving serious injury including, <u>but not limited to</u>: brain injury, unexpected death, blindness (in one or both eyes), significant burns (including overexposure to radiation), significantly diminished life expectancy, injury to the spinal cord, significant sensory and motor loss, or loss of a significant portion of an arm or leg. Please give a brief description of each such claim, occurrence, incident or circumstance.

Incident #1
Name of Patient/Claimant:________________________________Age:_________ Sex:______________
Date(s) of Incident resulting in injury/demand:____
Location of Incident:____
Summary of Incident:____
____
Current Status:
_____Claim/Suite Made. Date ___/___/___ Open ______ Closed ______ No Claim/Suit Made ____
Amount of Reserve ___________________ Amount of settlement of Judgement ________________
Amount paid on applicant's behalf:_________________ If no payment, was claim/suit withdrawn?______

Name of Insurer:____
Additional Defendants or Medical Professionals Involved:______________________________________
____

Incident #2
Name of Patient/Claimant:________________________________Age:_________ Sex:______________
Date(s) of Incident resulting in injury/demand:____
Location of Incident:____
Summary of Incident:____
____
Current Status:
_____Claim/Suite Made. Date ___/___/___ Open ______ Closed _____ No Claim/Suit Made _____
Amount of Reserve ___________________ Amount of settlement of Judgement ________________
Amount paid on applicant's behalf:_________________ If no payment, was claim/suit withdrawn?______

Name of Insurer:____
Additional Defendants or Medical Professionals Involved:______________________________________

Please note that no coverage will be provided under the applied-for policy, for any such claim, occurrence, incident or circumstance permitted to be reported to your current insurance provider*. (*Insurance Provider includes any self-insurance, or any other financial mechanism, whether public or private, established for the purpose of paying awards, judgments or settlements for loss or damages against insured entitled to participate in such mechanism).

The above is true to the best of my knowledge, information and belief. I understand that misrepresentations, omissions, concealment of facts, or incorrect statements in this application which are fraudulent, or material either to acceptance of the risk or to any hazard assumed by PPIX. may result in denial of coverage under the applied for insurance for any claims(s) arising there from. This application will become part of the policy.

Date____________________ Applicant Signature ____