ACORD™ MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

DATE

PRODUCER
PHONE (A/C, No, Ext):
FAX (A/C, No):

APPLICANT (First Named Insured)

SOCIAL SECURITY #

DEA # (IF APPLICABLE)

CODE: SUB CODE:
AGENCY CUSTOMER ID:

DATE OF BIRTH

US CITIZEN? ☐ YES ☐ NO

PRIMARY BUSINESS ADDRESS
PHONE (A/C, No, Ext):

MAILING ADDRESS
PHONE (A/C, No, Ext):

COVERAGE/LIMITS

☐ CLAIMS MADE ☐ OCCURRENCE

$ AGGREGATE
$ EACH OCCURRENCE
$ OTHER

PROPOSED EFFECTIVE DATE
PROPOSED RETROACTIVE DATE

PROFESSION

☐ PHYSICIAN -- PRIMARY PRACTICE: SECONDARY PRACTICE:
☐ SURGEON -- SPECIALTY: OTHER:
☐ PHYSICIAN'S ASSISTANT ☐ PERFUSIONIST ☐ NURSE PRACTITIONER
☐ NURSE ANESTHETIST ☐ REGISTERED NURSE ☐ COUNSELOR
☐ SURGEON'S ASSISTANT ☐ LICENSED PRACTICAL NURSE ☐ OTHER (SPECIFY):
☐ PSYCHOLOGIST ☐ OPTOMETRIST
☐ NURSE MIDWIFE ☐ EMERGENCY MEDICAL TECHNICIAN

PERSONAL INFORMATION

TYPE OF CERTIFICATION CURRENTLY HELD

STATES IN WHICH YOU ACTIVELY PRACTICE

STATE LICENSE #

STATE LICENSE #

STATE LICENSE #

EDUCATION (LIST MOST RECENT ATTENDANCE FIRST)

INSTITUTION	DATES OF ATTENDANCE MO/YR	MO/YR	DATE GRADUATED	CERTIFICATION OR DEGREE RECEIVED

LIST CONTINUING EDUCATION COURSES AND CREDITS RECEIVED WITHIN THE LAST 2 YEARS (OR ATTACH COPIES OF CERTIFICATES AND/OR CREDITS RECEIVED)

HAS YOUR CERTIFICATION/LICENSE IN ANY STATE EVER BEEN (VOLUNTARILY OR OTHERWISE) SUSPENDED, DENIED, REVOKED, RESTRICTED OR LIMITED IN ANY WAY? IF YES, EXPLAIN.
☐ YES ☐ NO

CURRENT PRACTICE (DESCRIBE GENERAL DUTIES AND EXTENT OF SUPERVISION (IF ANY)

LIST ANY ASSOCIATION/SOCIETY/MEMBERSHIPS RELATED TO YOUR PROFESSION

PRESENT EMPLOYEES AND POSITIONS

LOSS HISTORY

ENTER ALL CLAIMS (REGARDLESS OF FAULT) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY) ☐ CHK HERE IF NONE ☐ SEE ATTACHED LOSS SUMMARY

DATE OF OCCURRENCE	LINE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	CLAIM STATUS
						☐ OPEN ☐ CLOSED
						☐ OPEN ☐ CLOSED

PRIOR CARRIER INFORMATION

CATEGORY					
CARRIER					
POLICY NUMBER					
POLICY TYPE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE	☐ CLAIMS MADE ☐ OCCURRENCE
RETRO DATE					
EFF-EXP DATE					
GENERAL AGGREGATE					
EACH OCCURRENCE					

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES IN REMARKS	YES	NO	EXPLAIN ALL "YES" RESPONSES IN REMARKS (Except question 15, 16 and 17)	YES	NO
1. HAVE YOU EVER BEEN INSURED BY MUTUAL ASSURANCE OR MEDICAL ASSURANCE FOR PROFESSIONAL LIABILITY?			4. HAVE ANY FEE OR PROFESSIONAL RELATION COMPLAINTS BEEN REGISTERED AGAINST YOU WITH YOUR PROFESSIONAL ASSOCIATION(S), HOSPITAL(S) OR ANY STATE LICENSING AUTHORITY?		
IF YES, LIST POLICY # OR NAME OF PREVIOUS EMPLOYER			5. HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A CRIMINAL OFFENSE?		
2. IF PROFESSIONAL LIABILITY COVERAGE IS PROVIDED THROUGH YOUR EMPLOYER, DO YOU MAINTAIN A SEPARATE POLICY FOR PROFESSIONAL LIABILITY? IF SO, PLEASE PROVIDE A COPY OF YOUR DECLARATIONS PAGE. A CERTIFICATE OF INSURANCE MAY ALSO BE REQUIRED.			6. HAS YOUR PROFESSIONAL LIABILITY INSURANCE EVER BEEN CANCELED, SUSPENDED, NON-RENEWED, DECLINED OR ISSUED ONLY ON SPECIAL TERMS?		
			7. ARE YOU A SUBSIDIARY OF ANOTHER ENTITY OR DO YOU HAVE ANY SUBSIDIARY?		
3. HAVE YOU EVER BEEN DIAGNOSED WITH OR PROFESSIONALLY ADVISED TO SEEK TREATMENT FOR ALCOHOL/DRUG ABUSE OR ADDICTION, MENTAL ILLNESS OR CHRONIC PHYSICAL ILLNESS?					

REMARKS

SIGNATURE

THIS APPLICATION IS THE BASIS FOR COVERAGE; THEREFORE, ANY INCORRECT OR INCOMPLETE STATEMENTS OR ANSWERS COULD NULLIFY COVERAGE. COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.

I HEREBY REQUEST THAT MY APPLICATION FOR INSURANCE COVERAGE BE SUBMITTED FOR CONSIDERATION TO THE COMPANY SHOWN IN THIS APPLICATION. ACCORDINGLY, I AUTHORIZE AND DIRECT ANY PERSON OR ORGANIZATION WHATSOEVER TO RELEASE AND FURNISH TO THAT COMPANY ANY AND ALL INFORMATION REQUESTED WHICH MAY RELATE TO MY INSURABILITY.

I HEREBY WARRANT AND REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT AN INCORRECT OR INCOMPLETE STATEMENT OR ANSWER COULD VOID MY PROTECTION.

I HEREBY CONSENT TO THE REVIEW BY THE COMPANY SHOWN IN THIS APPLICATION OF ANY INCIDENTS OR OCCURRENCES LIKELY TO RESULT IN MALPRACTICE ALLEGATION OR CLAIM. I AGREE TO COOPERATE IN THE REVIEW OF CLAIMS AND INCIDENTS WHICH APPLY TO THE COVERAGE REQUESTED.

WHERE APPLICABLE, I HEREBY CONSENT TO THE REVIEW OF MY APPLICATION BY THE COMMITTEES APPOINTED BY MY COUNTY OR STATE PROFESSIONAL ASSOCIATION/SOCIETY. I AGREE TO COOPERATE WITH THESE COMMITTEES.

NOTICE OF INSURANCE INFORMATION PRACTICES

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION AND SUBSEQUENT RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCESBE DISCLOSED TO THIRD PARTIES. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTION ON HOW TO SUBMIT A REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. NOT APPLICABLE IN CO, HI, OH, OK, OR, VT; IN DC, LA, ME, VA, INSURANCE BENEFITS MAY ALSO BE DENIED.

APPLICANT'S SIGNATURE		PRODUCER'S SIGNATURE	