Application

Certified Registered Nurse Anesthetists

Professional Liability Insurance

PHYSICIANS' RECIPROCAL INSURERS

Home Office: 1800 Northern Boulevard
Roslyn, New York 11576

Telephone: (516) 365-6690 (800) 632-6040
Fax: (516) 365-7522

Rochester Office: 1200C Scottsville Road, Suite 195
Rochester, New York 14624

Telephone: (585) 328-8860 (800) 329-8860
Fax: (585) 328-8686

PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY

PLEASE PRINT or **TYPE** all information and make sure all questions are answered in full.

Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.

If you have had claims or suits filed against you, please make certain you have a completed claims information form for each claim or suit in the past 10 years.

Upon acceptance of your application you will be notified of premium due. Upon payment of the premium, your policy will become effective.

FOR ASSISTANCE, APPLICANT MAY CALL OUR HOME OFFICE AT ANY ONE OF THE NUMBERS LISTED ABOVE.

PHYSICIANS PROFESSIONAL LIABILITY POLICY APPLICATION
TO: PHYSICIANS RECIPROCAL INSURERS, an Exchange

CRNA APP

APPLICATION FOR CERTIFIED REGISTERED NURSE ANESTHETISTS

APPLICANT MUST ANSWER ALL QUESTIONS

If my application is approved, make coverage effective on _____ if possible, otherwise on any other date set by the Exchange.

1. Name: _____ Birthdate: _____/____/____
   Last First Middle

   S.S. # _____ Email_____ ☐ Male ☐ Female

2. Home Address: _____
   Number & Street

   _____
   City County State Zip Code

3. Name of Employer: _____

4. Address of Employer: _____
   Number & Street

   _____
   City County State Zip Code

5. Employer Practices as: ☐ Individual Practitioner
   ☐ Partnership
   ☐ Professional Corporation

6. Name of Supervising Doctor: _____
   Name Specialty Policy Number

   Telephone # _____
   Office

7. Applicant's professional training:

NAME OF SCHOOL HOSPITAL, ETC.	From/To	TYPE OF TRAINING	DATE OF COMPLETION

8. a) License Number: _____
   * Please attach copy of registration with application.

   b) If certified or registered by a professional organization, provide full name, certification or registration number and corresponding date. _____

9. Has any insurance company ever canceled or declined to renew professional liability insurance?
   _☐_ Yes _☐_ No

   If "Yes", explain: _____
   _____

10. Have you ever had a malpractice claim or suit (closed or pending) asserted against you?
    _☐_ Yes _☐_ No.

    If "Yes", state present status of each such claim or suit. Give details, which should include: name of patient, dates and description of treatment, and amount of settlement (if applicable).

    _____
    _____
    _____

11. Indicate by X the Limits of Liability you wish the policy to provide.

    CHECK ONE: **LIMITS OF LIABILITY**

    _☐_ 500,000 per claim/1,500,000 annual aggregate

    _☐_ 1,000,000 per claim/3,000,000 annual aggregate

    _____

    YOU MUST MAINTAIN THE SAME LIMITS OF LIABILITY AFFORDED BY THE COMPANY TO YOUR SUPERVISING/EMPLOYING PHYSICIAN.

12. List malpractice coverage for past 10 years:

Name of Carrier	Dates Covered From/ To	Limits of Liability	Claims-Made or Occurrence	Number of Claims
1.				
2.				
3.				
4.				

13. Paragraph 44 of the Subscriber's Agreement provides for the return of a portion of the amount in the Subscriber's separate account which represents the Subscriber's share of the earnings of the Exchange during his/her term as a Subscriber. Such amount must be returned to the Subscriber after he/she is no longer insured by the Exchange. However, in instances where the Subscriber's premium will be paid by a person or entity other than the Subscriber, the Subscriber may agree in advance to assign such distribution and designate the person or entity which has paid the premium to receive such distribution by signing below and naming such recipient:

_____ _____

Subscriber's Signature Name of Recipient

14. You may appoint a policy administrator authorized to receive all communications, make requests and give instructions on your behalf with regards to your policy, except for consenting to settlement of a claim if such consent is required by the policy. Please identify the policy administrator by completing the below:

Name: _____

Title: _____

Address (mailing)_____

_____

_____

Phone _____
Fax _____
E-mail _____

RELEASE OF INFORMATION

I hereby authorize Physicians' Reciprocal Insurers to obtain full information from any insurance company or from any person with respect to any claim or suit or incident pertaining to professional acts or omissions asserted against me. I expressly release and discharge from liability any insurance company or persons providing such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

I understand and agree that, if I am approved as a Subscriber to the Exchange and a policy issued to me, that there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant to the Exchange with this application.

I understand that in order to underwrite professional liability insurance, the Exchange must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice, which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Exchange pursuant to this consent and direction, together with the agents, employees, or offices of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

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 IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

Signature _____ Date _____

APPLICANT'S SIGNATURE

☐ **Please check box if you are submitting electronically only.**

☐ I fully understand that by checking this box I am accepting the terms and conditions stated above.

Claim Information

1. Name of Patient _____ 2. Age _____ 3. Sex _____

4. Allegation and your relationship to patient (e.g.: attending physician, primary surgeon, asst. surgeon, etc. _____
_____
_____

5. Date of Incident _____ 6. Location _____

7. Insurance Carrier _____

8. Other Defendants: _____

9. Present Status: Open Claim ☐
Closed Claim ☐ Loss $_____ Date Closed _____
Settlement _____ Judgment _____

10. Condition and diagnosis at time of incident:
_____
_____
_____

11. Dates and description of treatment rendered: _____
_____
_____

12. Condition of patient subsequent to treatment and DATES OF FOLLOW-UP TREATMENT
_____
_____
_____

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Signed: _____ Date Signed: _____