Application

Physician Assistants

Nurse Practitioners

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 open suit or closed 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.

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

APPLICATION FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Please note: Coverage is available on an Occurrence basis only

1. Applicant's Full Name: _____ Birth Date:_____

   Applicant's Maiden Name:_____

   ☐ Male ☐ Female

   a) Home Address: _____

   _____

   b) Home Phone Number: _____

   c) Practice Location: _____

   _____

   d) Phone Number: _____ Email Address: _____

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

3. ☐ Physician Assistant ☐ Nurse Practitioner

   License Number: _____

   *** Please attach copy of registration with application.**

4. a) Social Security Number: _____

5. <u>Education and Practice</u>

   What P.A./N.P. training program did you attend?

   _____

   Name

   _____

   City/State/Country

   Year Graduated: _____

6. Practice/Insurance Information

Indicate rate for which you are applying:

- ☐ Full Time
- ☐ Part Time (requesting coverage for 20 hours total or less a week)
- ☐ Locum Tenens (per diem rate for substitution for another Insured)
- ☐ New Practitioner (new to private practice)

If you have checked (b) above, please complete the following regarding any practice outside of the location for which you are applying for coverage:

Name and Address of Location	No. of Hours worked per week	Insurance Carriers

7. List all locations where you have practiced in the last 10 years:

	Street	City	State	From/To
a)				
b)				
c)				
d)				

8. 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.					
5.					

9. Governmental Action

a. Has any governmental agency **ever** investigated, suspended, revoked, or taken any other action against either your narcotic license, your license to practice or your registration?

☐ Yes ☐ No

If yes, explain in Remarks, #

b. Have you **ever** been convicted of a crime? ☐ Yes ☐ No

If yes, explain in Remarks, #

10. Health

Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?

☐ Yes ☐ No

If yes, explain in Remarks, #

If yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

11. Claims or Suits

Have you **ever** been named as a defendant in a malpractice claim or suit, or are you presently involved in malpractice litigation?

☐ Yes ☐ No

If yes, submit a separate form for each case in the last 10 years (see page 8).

12. The following statement summarizes the supervisory relationship I have with my physician employer.

☐ My employing physician is physically supervising me at all times.

☐ My employing physician is physically supervising me except when I am making house calls.

☐ My employing physician is supervising me by phone or beeper. I am always able to get in touch with my employing physician.

13. We ask that you delineate below the duties you will perform in your role as physician assistant or nurse practitioner.

While employed by _____, PRI insured.

_____

_____

_____

14. What is the supervising physician's method for evaluating the quality of care by the Nurse Practitioner or Physician's Assistant?

_____

_____

_____

_____	_____	_____
Signature, PRI Physician Insured	Policy No.	Signature, Physician Assistant or - Nurse Practitioner

15. Remarks:

_____
_____
_____
_____
_____

16. 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

17. 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 _____

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 officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

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.

Signature: _____ Date: _____

☐ **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
_____
_____
_____

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
_____
_____
_____

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.

Signed: _____ Date Signed: _____