PMSLIC
MEDICAL LIABILITY INSURANCE

P.O. BOX 2080, MECHANICSBURG PA 17055-0787
800 445-1212 **T** 717 796-8080 **F** PMSLIC.com

APPLICATION FOR DESIGNATED EMPLOYEE LIABILITY COVERAGE AVAILABLE UNDER A PMSLIC PHYSICIAN, ENTITY OR GROUP POLICY ONLY

Please complete the entire application. Indicate not applicable (n/a) where appropriate.

Producer Name

PART I NAME AND ADDRESS

First Name _____ Middle Name _____ Last Name _____

☐ Male ☐ Female _____ Date of Birth _____ Pennsylvania License Number

Home Address _____ City _____ State _____ Zip Code _____

Home Telephone _____

PART II COVERAGE INFORMATION — ATTACH A COPY OF YOUR DECLARATIONS PAGE FROM YOUR MOST RECENT INSURANCE POLICY.

A. Coverage Desired

☐ Claims-made without prior acts coverage. Under this option the retroactive date will be the same as the effective date of coverage.

☐ Claims-made with prior acts coverage. Under this option the retroactive date will be the same as the retroactive date on your current policy.

Requested effective date 12:01 a.m. _____ Retroactive Date _____

B. Previous Professional Liability Insurers

List all previous professional liability insurance you have had for the past five years, beginning with the most current.

1. _____ Insurer ☐ Occurrence ☐ Claims-made _____ mm/dd/yyyy to _____ mm/dd/yyyy

2. _____ Insurer ☐ Occurrence ☐ Claims-made _____ mm/dd/yyyy to _____ mm/dd/yyyy

3. _____ Insurer ☐ Occurrence ☐ Claims-made _____ mm/dd/yyyy to _____ mm/dd/yyyy

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

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

NOTE: Limits of $1,000,000 / $3,000,000 are available only if you are required to carry the higher limits for credentialing or licensing reasons.

C. Indicate average weekly practice hours for which PMSLIC insurance is desired: hour(s)/week _____

D. Will you also carry insurance with another company? ☐ **YES** ☐ **NO** If **YES**, please provide details.

E. PMSLIC Insured Employer _____ PMSLIC Policy Number _____

PART III CLAIMS INFORMATION

Do you have any open/pending malpractice claims or suits filed against you? ☐ **YES** ☐ **NO**

Have you had any malpractice claims or suits filed against you, settled, dismissed or discontinued? ☐ **YES** ☐ **NO**

If **YES** to either question above, please complete a Claims Information Supplement.

PART IV MEDICAL EDUCATION/GENERAL INFORMATION

A. ☐ Certified Nurse Midwife ☐ CRNA ☐ Nurse Practitioner ☐ Surgical Assistant
☐ Physician's Assistant ☐ Optometrist ☐ Other: _____

B. Professional School: Name of School _____ Year Graduated _____

City _____ State _____ Country _____ Degree _____

C. List any additional training

LOCATION	**TYPE**	**DATES**

D. Nurse Practitioner
Do you have a collaborative agreement? ☐ **YES** ☐ **NO**

If **YES**, provide the name of the physician: _____

E. Does your employment require you to work in an operating room? ☐ **YES** ☐ **NO**

If **YES**, do you ☐ observe ☐ assist ☐ other (explain): _____

Please provide a brief description of your general duties:

F. Does your employment require you to work in a labor and delivery room or birthing center? ☐ **YES** ☐ **NO**

If **YES**, do you perform duties under direct physician supervision? ☐ **YES** ☐ **NO**

Please provide a brief description of your general duties:

PART V PRACTICE AND HOSPITAL LOCATIONS — percentages must total 100%.
NOTE: Please base percentage of practice on the number of patients treated.

A. PRACTICE LOCATIONS — LIST PRINCIPAL LOCATION FIRST

1. _____
Address

_____ _____ _____
City State Zip Code

_____ _____
County % of Practice

2. _____
Address

_____ _____ _____
City State Zip Code

_____ _____
County % of Practice

3. _____
Address

_____ _____ _____
City State Zip Code

_____ _____
County % of Practice

PART V PRACTICE AND HOSPITAL LOCATIONS — percentages must total 100%. (continued)

B. HOSPITAL LOCATIONS — Do you have hospital staff privileges? ☐ **YES** ☐ **NO** If **YES**, please indicate below:

1. _____
Hospital Name

_____ _____ _____ _____
City County State Zip Code

_____ _____
Type of Privileges % of Practice

2. _____
Hospital Name

_____ _____ _____ _____
City County State Zip Code

_____ _____
Type of Privileges % of Practice

3. _____
Hospital Name

_____ _____ _____ _____
City County State Zip Code

_____ _____
Type of Privileges % of Practice

C. Will you practice out of state subsequent to the requested date of coverage? ☐ **YES** ☐ **NO**

If yes, state(s) _____ Percent of Practice _____

PART VI ADDITIONAL INFORMATION

A. During the past year, have you incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical specialty? If **YES**, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. ☐ **YES** ☐ **NO**

B. Have you been charged or convicted of any crime other than minor traffic violations? If **YES**, provide details. ☐ **YES** ☐ **NO**

C. Have you had your privileges or license either voluntarily or involuntarily revoked, suspended, restricted, subject to a reprimand, placed on probation? If **YES**, provide details ☐ **YES** ☐ **NO**

D. Has any insurer ever cancelled, declined, refused to renew or only accepted on special terms your professional liability insurance? If **YES**, provide details. ☐ **YES** ☐ **NO**

Use this space to provide additional information that would be helpful in reviewing your application for insurance.

1. I hereby declare that, to the best of my knowledge and belief, all the statements in this application, including any supplemental materials, are true and correct and I have not knowingly withheld any information which is calculated to influence the judgment of PMSLIC in considering this application for professional liability insurance. I understand that any material misrepresentation in this application which PMSLIC relies on to its detriment shall void coverage.

2. I hereby authorize PMSLIC to obtain full information from any person or insurance companies with respect to any claim or suit pertaining to professional acts or omissions asserted against me. I further authorize and consent to the release of information by a hospital/facility, its medical staff, medical associations or licensure board on request regarding any information they may have concerning my staff privileges and/or licensure.

3. I understand that this application is subject to acceptance by PMSLIC and does not bind coverage.

_____ _____

Signature of Applicant Date

PLEASE DATE AND SIGN ABOVE AND RETAIN A COPY OF THIS APPLICATION FOR YOUR FILES.

Pennsylvania law requires that we notify you of the following:

Any person who knowingly and with the 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 subjects such person to criminal and civil penalties.