COVERYS RRG

Allied Healthcare Professional (AHP)
Professional Liability Application

Coverys RRG, Inc.

NOTICE: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

PART I - PRODUCER INFORMATION

Agency Name | Submitted By

Agency License Number | State | Telephone | Most Recent Coverys RRG Policy Number

PART II - APPLICANT INFORMATION

First Name | Middle Initial | Last Name | ❑ Male ❑ Female | Social Security Number | Date of Birth

Email Address | Website

Contact Person/Insured Representative | National Provider Identifier

Office Address One
Percentage of practice: ____________
Address One
Address Two
City State Zip
Phone Fax

Residence Address
Address One
Address Two
City State Zip
Phone Fax

Office Address Two
Percentage of practice: ____________
Address One
Address Two
City State Zip

Mailing Address
(if different from office address one)
Address One
Address Two
City State Zip

Office Address Three
Percentage of practice: ____________
Address One
Address Two
City State Zip

Billing Address
(if different from office address one)
Address One
Address Two
City State Zip

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed	Additional Malpractice Insurance
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No

Is there any part of your practice that is covered by any other professional liability? ❑ Yes ❑ No

If yes, please provide details and copy of declaration page of policy: ____________________

____

Name and location of all healthcare facilities where you have medical staff or courtesy privileges:

Facility Name	City	State	JCAHO Approved?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

PART IV - COVERAGE INFORMATION

Type of Coverage (choose one)

❑ Occurrence ❑ Claims Made Retroactive date desired* ____________________

❑ Moonlighting Only (When selected, please complete and submit CRRG APP 017, Moonlighter Credit Addendum.)

Coverage Effective Date

From ______________ To ______________

Do you wish to purchase Prior Acts Coverage? ❑ Yes ❑ No (If yes, please complete and submit CRRG APP 015, Prior Acts Application.)

*The retroactive date is the date first continuously insured under a claims made policy. If the retroactive date is prior to the coverage effective date, a 'no known loss' letter is required.

Professional Liability

Each Claim $ ____________________ Annual Aggregate $ ____________________

You may choose to have a deductible apply to your limit of liability for a premium credit. Deductible amounts range from $5,000 to $1 million per claim with an aggregate of three times the per claim amount. Prior to adding a deductible to your policy the deductible must be fully collateralized. Would you like more information on deductibles? ❑ Yes ❑ No

PART V - EDUCATION

Country	State/Province	School of Graduation	Type of Degree:
			Graduated: *(month)* *(year)*

List any post-graduate programs completed: ____________________ Month: ________ Year: ________

Have you participated in any CEU programs within the last five years? If yes, please attach a description or a copy of a certificate of completion. ❑ Yes ❑ No

Which professional organizations are you a member of? ❑ACNM ❑National Nursing ❑State Nursing ❑Other ____________________

Are you certified by an approved specialty board? ❑ Yes ❑ No

If so, list specialty and attach a copy of the certificate(s): ____________________ Date Certified: *(month)* ________ / *(year)* ________

PART VI - CURRENT PRACTICE

Type of practice: ❑ Individual ❑ Partnership ❑ Solo Corporation ❑ Professional Corporation or Association ❑ Locum Tenens

Nurse Practitioners only: Do you practice as an employee or are you self-employed? ❑ Employee ❑ Self-employed

Separate Limit of Liability for Partnership or Corporation

Not available on solo corporations (except in PA). Current practice must be partnership or corporation. ❑ Yes ❑ No

If yes, please complete and submit ***CRRG APP 008, Partnership & Corporation Professional Liability Application***.

Partnership or Corporation *(complete this section)*

Name of Partnership or Corporation

Name of partner(s) or other members

If you are employed by others, or perform services on behalf of others as an independent contractor, list the names of those other persons or entities.	Employment Status
	❑ Employee ❑ Independent Contractor
	❑ Employee ❑ Independent Contractor
	❑ Employee ❑ Independent Contractor

Are you covered by the Federal Tort Claims Act? (If yes, please complete and submit CRRG APP 024, FTCA Restricted Coverage.) ❑ Yes ❑ No

Do you practice less than 21 hours per week in direct patient care services? (If yes, please complete and submit CRRG APP 020, Limited Practice Credit.) ❑ Yes ❑ No

Do you hold a full time teaching appointment with regular clinical supervision responsibilities? (If yes, please complete and submit CRRG APP 021, Academic Credit.) ❑ Yes ❑ No

Do you use Locum Tenens? ❑ Yes ❑ No

If yes, indicate the number of days per year: ____________________ days

PART VII - PRACTICE ACTIVITIES

Nurse Practitioners, please indicate your practice activities below:

___ Specialize in Adult, Adult Oncology, Family Planning, Geriatric, Gynecology or Women's Healthcare

___ Specialize in Psychiatric Care

___ Specialize in Acute Critical Care, Family Practice, School Nurse, Pediatric or Neonatal Care

___ Specialize in Acute Critical Care OB/GYN, Obstetrics/Gynecology or Perinatal Care

If your specialty is OB/GYN, are you responsible for any labor or delivery? ❑ Yes ❑ No ❑ N/A

Do you perform any invasive surgical procedures? ❑ Yes ❑ No

If yes, please list procedures: ____________________

Do you have a written collaborative agreement with the physician(s) with whom you practice? ❑ Yes ❑ No ❑ N/A

Physician Assistants, please indicate your practice activities below:

___ PA 1: Carry out duties generally performed by a licensed physician and practice under the direction and supervision of a licensed physician to assist in the diagnosis and treatment of patients. No surgical procedures.

___ PA 2: Select if your practice includes any of the following:
Assist a licensed physician in surgery, have any practice exposure in an operating room other than for observation; practice 10 hours a week or less in trauma/emergency room; provide obstetrical-prenatal or postnatal care only; assist a physician in anesthesiology.

___ PA 3: Select if your practice includes any of the following:
Assist in surgery; practice 10 hours or more per week in trauma/emergency room; provide obstetrics including prenatal/postnatal care and delivery room responsibilities; have contact or exposure with cardiac catherization labs; assist in cosmetic/aesthetic procedures.

Does your supervising physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives? ❑ Yes ❑ No

Do you want employee coverage under separate limits? ❑ Yes ❑ No

*Protects your healthcare employees for their acts while under your employ. All employees automatically share in your professional liability limits. To purchase separate limits for employees under your professional liability coverage for a premium charge, check "Yes" and complete **CRRG APP 026, Employee Limit of Liability Application**.*

Nurse Practitioners and Physician Assistants, please answer the following questions:

Have you completed a risk management course in the last 12 months? *(If yes, please attach a copy of the certificate)*

Do you or any of your employees perform any type of cosmetic procedures such as Botox, Collagen or dermal filler injections, etc.? ❑ Yes ❑ No

(If yes, please complete and submit CRRG APP 042, Botox/Cosmetic Procedures Addendum.)

Do you participate in any medical research, clinical trials or off-label use of drugs or devices? ❑ Yes ❑ No

(If yes, please complete and submit CRRG APP 040, Clinical Trials Addendum)

Do you provide services in a correctional facility? ❑ Yes ❑ No

If yes, please list the name of the facility: ____

Do you participate in any telemedicine activities? *(If yes, please complete and submit CRRG APP 043, Telemedicine Addendum.)* ❑ Yes ❑ No

PART VIII - EMPLOYEES/ADDITIONAL INSUREDS

Please list the following for any physicians, surgeons or certified nurse midwives you employ. (Use additional space if necessary.) For each employee identified as an independent contractor please complete *CRRG APP 041, Independent Contractor Addendum.*

First Name				
Middle Initial				
Last Name				
Insurer				
Policy #				
Social Security #				
NPI #				
Date of Birth				
Independent Contractor	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Coverys RRG Insured	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Applying for Coverys RRG Coverage	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Specialty				
Surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery	❑ No surgery ❑ Major surgery ❑ Minor surgery
Assisting with Surgery	❑ Own patients ❑ Other's patients	❑ Own patients ❑ Other's patients	❑ Own patients ❑ Other's patients	❑ Own patients ❑ Other's patients
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Graduation Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Residency Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*
Fellowship Date	*month* *year*	*month* *year*	*month* *year*	*month* *year*

If you employ non-physician healthcare providers, please list job category and number of each. If you employ nurses, please specify between RNs, LPNs, Nurse Practitioners, etc.

Job Title/Specialty	Number of Employees

PART IX - HISTORY

(Practice/Claims/Insurance for a minimum of the last 15 years - Start with the most recent, and attach additional sheet if necessary.)

Dates	*From* *To*	*From* *To*	*From* *To*	*From* *To*
Insurer				
Policy #				
Coverage				
Premium				
Tail Purchased	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Retroactive Date				
Limit				
Facility				
State				
Any claims?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Attach an entire loss history which includes: policy number, claim number, report dates, description of loss and settlement amount.

Have you ever been denied a nursing license or been denied certification by a specialty board? ❑ Yes ❑ No

Has your professional license ever been restricted, suspended, voluntarily surrendered or revoked in any state? ❑ Yes ❑ No

Has any hospital ever brought complaints or actions against you such as restriction, suspension, revocation of privileges or probation? ❑ Yes ❑ No

Have you ever been involved in or are you aware of any future involvement in an investigation by a regulatory agency or peer review board? ❑ Yes ❑ No

Have you ever had a complaint or claim brought against you for sexual misconduct? ❑ Yes ❑ No

Do you now or have you ever had any chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree? ❑ Yes ❑ No

Have you ever been indicted and/or convicted of a crime other than minor traffic violations? ❑ Yes ❑ No

Have you ever been suspended, restricted, or put on probation by any governmental health program (e.g., Medicare or Medicaid)? ❑ Yes ❑ No

If you answered yes to any of the above questions, you must provide a detailed written narrative.

Do you now or have you ever had a drug or alcohol addiction or dependency or sought treatment for such? ❑ Yes ❑ No

If yes, please accompany this application with a letter outlining dates of treatment, results of treatments, and current status. This letter should be from your treating physician or institution.

Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? ❑ Yes ❑ No
(If yes, please list company, date and reason for this action below.)

Company ____________ Date ____________ Reason ____________

Company ____________ Date ____________ Reason ____________

PART X - OPTIONAL COVERAGES

Check Yes if you are interested in any of the following coverages. Unless otherwise indicated, these coverages require both an additional application and an additional charge over and above your professional liability premium. Applications for optional coverages can be obtained from the company.

Professional Contractual Liability ❑ Yes ❑ No
Protects you against certain hold harmless agreements in managed care contracts. *Purchase of this coverage does not provide a separate limit of insurance*. There is a charge based on a percentage of your professional liability premium.

For New Jersey Applicants Only - Consent to Settle
The right to consent to settle is automatically provided to all individual and group policies. It requires the Company to obtain your written consent before settling any claims brought against you. You may choose to waive this right for a 5% premium credit to your policy. Would you like to waive this right?
❑ Yes ❑ No

PLEASE ATTACH A COPY OF THE FOLLOWING TO THIS APPLICATION:

- ❑ Copy of current Declaration Page
- ❑ Curriculum vitae (C.V.) for applicant and each employed or contracted physician
- ❑ Loss runs from all carriers for prior 15 years, or since the start of the practice, whichever is greater
- ❑ A narrative of all past claims - *a Claim Information Form may be used when necessary*
- ❑ Signed Notice to New Applicants (CRRG APP 028) for claims made policies
- ❑ Signed Anti-Fraud Statement (New Jersey)
- ❑ Copies of license to practice and board certification
- ❑ Copy of previously purchased tail policies, if applicable.

READ CAREFULLY BEFORE SIGNING

THE STATEMENTS IN THIS APPLICATION, TOGETHER WITH ANY SUPPLEMENTAL APPLICATIONS, ATTACHMENTS AND ANY OTHER INFORMATION SUBMITTED TO THE COMPANY IN CONNECTION WITH THIS APPLICATION WILL BE REFERRED TO AS THE "POLICY APPLICATION."

REPRESENTATIONS AS TO ACCURACY OF APPLICATION, THE AUTHORITY OF PERSON SIGNING, AND APPLICANT'S OBLIGATION TO SUPPLEMENT INFORMATION

BY SIGNING BELOW, I REPRESENT AND CERTIFY: (I) THAT THE INFORMATION CONTAINED IN THE POLICY APPLICATION IS TRUE AND ACCURATE. (II) THAT I HAVE MADE ALL REASONABLE EFFORTS TO INVESTIGATE THE ACCURACY OF THE INFORMATION PROVIDED IN THE POLICY APPLICATION AND TO OBTAIN SUCH INFORMATION FROM ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED POLICY AS IS NECESSARY TO PROVIDE TRUE AND ACCURATE INFORMATION IN THE POLICY APPLICATION; AND (III) THAT I AM DULY AUTHORIZED TO SIGN THIS POLICY APPLICATION ON BEHALF OF ALL PERSONS AND ENTITIES TO BE INSURED BY THE REQUESTED INSURANCE AND THAT I HAVE CAREFULLY READ THIS POLICY APPLICATION.

I ACKNOWLEDGE THAT OBTAINING THE REQUESTED INSURANCE, INCLUDING ANY RENEWALS OF THE REQUESTED INSURANCE, IS CONDITIONED UPON PROVIDING TRUE AND ACCURATE INFORMATION IN THIS POLICY APPLICATION, AND ANY SUCH INSURANCE THAT MAY BE ISSUED WILL BE BASED UPON THE COMPANY'S RELIANCE ON THE INFORMATION PROVIDED IN THE POLICY APPLICATION. I ALSO AGREE AND UNDERSTAND THAT THIS POLICY APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THAT THIS POLICY APPLICATION WILL BE DEEMED TO BE ATTACHED TO AND PART OF SUCH POLICY AND ANY RENEWALS OF SUCH POLICY, IF ISSUED. FURTHER, IF ANY INFORMATIONIN THE POLICY APPLICATION IS MISLEADING, INCOMPLETE OR FALSE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION.

ADDITIONALLY, I AGREE THAT IN THE EVENT THERE IS ANY CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION BEFORE THE EFFECTIVE DATE OF THE REQUESTED INSURANCE OR BEFORE ANY RENEWAL OF THE REQUESTED INSURANCE, I WILL IMMEDIATELY NOTIFY THE COMPANY IN WRITING. IF I FAIL TO PROVIDE SUCH NOTICE, THE COMPANY MAY VOID THE INSURANCE ISSUED PURSUANT TO THIS APPLICATION OR ANY RENEWAL OF THE REQUESTED INSURANCE. I UNDERSTAND THAT IF THERE IS A CHANGE IN THE INFORMATION PROVIDED IN THE POLICY APPLICATION THE COMPANY, IN ITS SOLE DISCRETION, MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NO OBLIGATION TO ISSUE OR PURCHASE INSURANCE

I UNDERSTAND THAT THE POLICY APPLICATION IS NOT A BINDER OF INSURANCE. ACCEPTING THE APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, OR ME TO PURCHASE, THE REQUESTED INSURANCE REGARDLESS OF WHETHER OR NOT I HAVE MADE PAYMENT, IN WHOLE OR IN PART, FOR THE REQUESTED INSURANCE OR THE COMPANY HAS DEPOSITED SUCH PAYMENT. I UNDERSTAND THAT THE REQUESTED INSURANCE SHALL NOT BE EFFECTIVE UNTIL I HAVE PAID A DEPOSIT TO THE COMPANY IN THE AMOUNT INVOICED BY THE COMPANY, REGARDLESS OF WHETHER OR NOT A POLICY OR ANY RENEWALS OF SUCH POLICY HAVE BEEN ISSUED.

AUTHORIZATION TO OBTAIN INFORMATION

THE COMPANY IS HEREBY AUTHORIZED TO OBTAIN FULL INFORMATION FROM ANY LIABILITY INSURER, HEALTHCARE INSURER, HOSPITAL, HEALTHCARE PROVIDER, MEDICAL ASSOCIATION OR SOCIETY, BOARD OF MEDICAL EXAMINERS, GOVERNMENTAL AGENCY, ATTORNEY OR OTHER PERSON OR ENTITY CONCERNING: (I) ANY MEDICAL MALPRACTICE CLAIM, SUIT, LICENSING BOARD PROCEEDING, CREDENTIALING PROCEEDING, DISCIPLINARY ACTION OR ANY OTHER CIVIL OR CRIMINAL ACTION ASSERTED AGAINST OR RELATING TO THE PROFESSIONAL CONDUCT OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE; (II) THE QUALIFICATIONS OF ANY PERSON OR ENTITY TO BE COVERED BY THE REQUESTED INSURANCE TO PERFORM PROFESSIONAL HEALTHCARE SERVICES; AND (III) SUCH OTHER INFORMATION WHICH, IN THE SOLE JUDGMENT OF THE COMPANY, MAY HAVE A BEARING ON WHETHER TO ISSUE THE REQUESTED INSURANCE. I AGREE TO HOLD HARMLESS ANY PERSON OR ENTITY PROVIDING SUCH INFORMATION TO THE COMPANY AND THE COMPANY, ITS DIRECTORS, OFFICERS, EMPLOYEES, AND AGENTS FROM ANY LIABILITY ARISING OUT OF THE DISCLOSURE OF SUCH INFORMATION, INCLUDING ANY LIABILITY ARISING OUT OF ERRORS AND OMISSIONS IN THE INFORMATION DISCLOSED.

NEW JERSEY APPLICANTS: IN ACCORDANCE WITH N.J. STAT § 17:33A-6 (C), ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

______________________________	______________________________
SIGNATURE OF APPLICANT	TITLE
______________________________	______________________________
PRINTED NAME	DATE