MD ADVANTAGE™ INSURANCE COMPANY OF NEW JERSEY

Application for Insurance:

Allied Health Care Employees Professional Liability (Separate Limits)

Please include a copy of your license with this application.

1. Name of Employer (providing this insurance):							
2. Employer's MDAdvantage Policy Number:							
3. Name of Applicant (Employee applying for coverage):							
4. Specialty:							
5. Requested Effective Date:				6. Limits of Insurance Requested:			
7. Current or Most Recent Insurance (Name of Company):							
8. Policy Number:				9. Policy Period:			
10. Type of Coverage: **(check one):**		Claims-made		Occurrence	11. Retroactive Date: (if Claims-Made):		
12. If Claims-made, was Extended Reporting ("Tail") Coverage purchased?	Yes	No	If "yes," please attach a copy.				

Claims History	**Yes**	**No**
In the past ten years, has any claim or suit been made against you arising from your professional services? If yes, please indicate the **number** of claims or suits and provide the information requested below:		

Claim No. ___ of ____ Name of Patient:

1. Date of medical incident or professional service that led to the claim against you:	4. Name of the insurance company that handled the claim:
2. Date claim was reported to your insurer:	5. Amount paid on your behalf:
3. Date claim was closed (or indicate if still open):	6. Amount of reserve, if claim is open (if known):

7. What medical treatment or professional service led to the alleged injury to the patient?
8. Describe the alleged injury or problem that led to the claim made against you:

Claim No. ___ of ____ Name of Patient:	
1. Date of medical incident or professional service that led to the claim against you:	4. Name of the insurance company that handled the claim:
2. Date claim was reported to your insurer:	5. Amount paid on your behalf:
3. Date claim was closed (or indicate if still open):	6. Amount of reserve, if claim is open (if known):

7. What medical treatment or professional service led to the alleged injury to the patient?

8. Describe the alleged injury or problem that led to the claim made against you:

Has Applicant ever had any action taken against his or her license by any licensing board or regulatory authority or ever been the subject of any disciplinary action by any hospital or other employer?	Yes	No

If "yes," please provide complete details:

Notice: Any person who includes false or misleading information on any application for insurance commits insurance fraud and may be subject to civil or criminal penalties.

Applicant certifies that the information in this application is true and correct and authorizes the release and exchange of any information regarding his or her medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which he or she is or has been a member and MDAdvantage Insurance Company of New Jersey. **Applicant** further agrees to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

Applicant's signature:_____ **Date**:_____

Employer authorizes MDAdvantage Insurance Company of New Jersey to add the Applicant to the policy referenced above and agrees to pay the premium on his or her behalf.

Employer's Signature:_____**Title**:_____ **Date**:_____