

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	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth
Email Address				Website	
Contact Person/Insured Representative				National Provider Identifier	
Office Address One			Residence Address		
Address One		Percentage of practice: _____	Address One		
Address Two			Address Two		
City	State	Zip	City State Zip		
Phone	Fax		Phone Fax		
Office Address Two			Mailing Address <i>(if different from office address one)</i>		
Address One		Percentage of practice: _____	Address One		
Address Two			Address Two		
City	State	Zip	City State Zip		
Office Address Three			Billing Address <i>(if different from office address one)</i>		
Address One		Percentage of practice: _____	Address One		
Address Two			Address Two		
City	State	Zip	City State Zip		

PART III - PRACTICE LOCATION(S)

License Number	State	% of Activities in each state	Coverage Needed	Additional Malpractice Insurance
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor
	<input type="checkbox"/> Employee <input type="checkbox"/> 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

How many deliveries do you perform per year? _____
 Do you perform first assists on Ceasarean sections? Yes No
 Do you perform vaginal deliveries after Ceasarean sections? Yes No
 Do you perform water births? Yes No
 Do you perform only uncomplicated vaginal deliveries? Yes No
 Do you work with a supervising obstetrician? If yes, name of obstetrician: _____ Yes No
 Is that physician readily available in case of emergency? Yes No
 Do you perform home deliveries? Yes No
 Do you work in a free standing birth center? Yes No
 If yes, how near is the closest hospital? _____ Yes No

Is there a formal agreement between the birth center and the hospital concerning the admission to the hospital of the birth center patients? Yes No

Do you have defined criteria for which patients would be low risk for this delivery setting? (If yes, please provide a copy of your criteria.) Yes No

Do you have a collaborative agreement(s) with both an OB and a facility to accept a patient in transfer? (If yes, please provide a copy of your agreement.) Yes No

Do you have an established medical emergency response and transfer plan? (If yes, please provide a copy of the plan.) Yes No

Do you have a developed quality management program? (If yes, please provide a copy of the program.) Yes No

Do you perform circumcisions? If yes, supply the average per month total: _____ Yes No

What methods do you use to control pain and apprehension in your practice? _____ Yes No

Do you or any of your employees perform Botox or Collagen injections? (If yes, please complete and submit APP 042, Botox/Cosmetic Procedures Addendum.) Yes No

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 APP 040, Clinical Trials Addendum.)

Do you provide services at a correctional facility? Yes No
(If yes, list where: _____)

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

PART VIII - EMPLOYEES/ADDITIONAL INSURED

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coverys RRG Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Applying for Coverys RRG Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specialty				
Surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery	<input type="checkbox"/> No surgery <input type="checkbox"/> Major surgery <input type="checkbox"/> Minor surgery
Assisting with Surgery	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients	<input type="checkbox"/> Own patients <input type="checkbox"/> Others' patients
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Does any one physician supervise more than four Physician Assistants, Nurse Practitioners or Certified Nurse Midwives? Yes No

If yes, please submit either a letter outlining practice guidelines or a copy of practice guidelines.

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**.*

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	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Retroactive Date								
Limit								
Facility								
State								
Any claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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? (If yes, please list company, date and reason for this action below.) Yes No

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**
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. Yes No

- 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 INFORMATION IN 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