Application for Coverage – Advanced Practice Professional

This application is for claims made coverage. Please read the policy carefully.

I. Employer Information

Name of Employer _____

Designated Contact _____

Office Address

_____ _____

Street City County State Zip Code

Office Phone: _____ Office Email: _____ Office Fax:_____

Location (s) at which you practice other than above: _____

_____

Website(s): _____

II. Ancillary Information

Full Name

_____

First Middle Last

Professional Designation:

☐CNM ☐CRNA ☐APN ☐LPN ☐NP ☐OD ☐OT ☐PA ☐PhD ☐PT ☐RN ☐Other_____

Your Address

_____

Street City County State Zip Code

Home Phone: _____ Cell Phone: _____ E-mail address: _____

Which is best way to contact you? ☐Home ☐Office ☐Cell Phone

Date of Birth: _____ NPI Number: _____

III. Limits of Liability

☐ **Shared Limits** ☐ **Separate Limits** ☐ **Same as Employer**

Texas Only:	☐ $200,000/$600,000	☐ $500,000/$1,000,000	☐ $1,000,000/$3,000,000
Florida Only:	☐ $250,000/$750,000	☐ $500,000/$1,000,000	
Pennsylvania Only:	☐ $500,000/$1,500,000	☐ $1,000,000/$3,000,000	
Remainder of States:	☐ $1,000,000/$3,000,000		

Requested **Effective Date**: _____ Requested **Retroactive Date**: _____

Are you purchasing tail coverage from your current carrier? ☐Y ☐N If yes, please provide a copy.

IV. Medical Licensure

State: _____ State: _____ State: _____
License #: _____ License #: _____ License #: _____
Expiration Date: _____ Expiration Date: _____ Expiration Date: _____

DEA License Number: _____
Have you ever had any of your licenses revoked, limited, refused, suspended or denied? ☐Y ☐N
If yes, give details _____
Please provide a copy of licensure and/ or certification.

V. Education/Training

School/ Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____ Degree: _____

VI. Certification

Certification(s) held: _____ Year _____ Recertified _____

Are you a member of an affiliated professional organization? ☐ Yes ☐ No

If so, please indicate _____

VII. Current Practices

Average number of hours worked per week? _____
Average number of patients seen per week? _____

VIII. Previous Insurance – Please provide ten (10) years of previous insurance information

Current Carrier	Effective Date	_____	Limit of Liability	_____
	Expiration Date	_____	Type of Coverage	_____
	Retroactive Date	_____	Premium	_____
Prior Carrier	Effective Date	_____	Limit of Liability	_____
	Expiration Date	_____	Type of Coverage	_____
	Retroactive Date	_____	Premium	_____
Prior Carrier	Effective Date	_____	Limit of Liability	_____
	Expiration Date	_____	Type of Coverage	_____
	Retroactive Date	_____	Premium	_____

IX. Claims Information

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? ☐Y ☐N
If yes, please complete a claim supplemental for each claim and provide prior carriers loss history.

Total Number of Claims: _____ Open/Reserved: _____ Closed: _____

Any change in your practice as a result of claims? _____
_____
_____
_____

X. Additional Background

Do you moonlight (work outside control of employer)? ☐ Yes ☐ No If yes, where _____

Have you ever (check all that apply):
☐ Had your license or certification investigated, suspended, revoked, restricted or placed under probation in any state?
☐ Had your professional liability insurance declined, suspended, non-renewed or canceled? *(Not Applicable to Missouri Applicants.)*
☐ Had any complaints filed against you with a hospital, regulatory or certifying authority?
☐ Been treated or hospitalized for mental or emotional disorder?
☐ Been charged with or convicted of a felony or misdemeanor other than minor traffic violations?
☐ Been treated for (or recommended treatment for) alcoholism, sexual or drug addiction?

Do you treat patients at a nursing home, assisted living facility, jail or correctional facility? ☐ Yes ☐ No
Do you perform any cosmetic procedures? ☐ Yes ☐ No

If yes, to any of the above, please explain. If necessary please give details on additional sheet.

*Warranty**

These warranties* are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware, or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by ALTOR National as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

* Some state laws permit the statements on the application to be only representations. If the policy will be issued in one of these states, your statements will be representations and not warranties.

Acknowledged and Agreed:

_____

Applicant Signature Date

Signing this application does not bind the Company to complete the insurance. All information in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.

Fraud Warnings:

Notice to Alabama Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Notice to Alaska Applicants: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Notice to Arizona Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Notice to Arkansas Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to California Applicants: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Notice to Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maine Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Minnesota Applicants: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Fraud Warnings continued:

Notice to New York Applicants: 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 such violation.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Oregon Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. In addition, if an insured or applicant misstates, misrepresents, omits or conceals information, and we rely on such misstatement, misrepresentation, omission or concealment and it is proven to be material to the policy or fraudulent, we may take action, including denying coverage for a claim or other covered event or rescinding, cancelling, or nonrenewing the policy or coverage.

Notice to Pennsylvania Applicants: 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 subjects such person to criminal and civil penalties.

Notice to Rhode Island Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Tennessee Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Washington Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Notice to West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This applicant declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify the Company of such changes and the company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

_____

Signature **Date**

_____

Printed Name **Title**

This application is not valid without your complete signature, date, printed name, and title above.

Altor National
SUPPLEMENT TO APPLICATION
CLAIM / SUIT / INCIDENT REPORT

Please complete this form for each claim, suit and/or incident for which you respond "Yes" on your Application. Answer in adequate detail to allow proper evaluation. Further documentation may be requested by the Underwriting Department.

1. Name of Patient _____ Age _____ ☐ Male ☐ Female

2. Date of Incident _____ Location of Incident _____
Insurance Carrier _____ Date Reported to Insurer _____

☐ Suit ☐ Demand for Money ☐ Incident Only
☐ Notice of Intent to Sue ☐ Request for Records ☐ Other _____

3. Summary of condition/diagnosis at time of incident

_____
_____
_____
_____
_____

4. Description of treatment rendered, including dates.

_____
_____
_____
_____
_____

5. Allegation

_____
_____
_____
_____
_____

6. Other physicians or entities involved

_____
_____

7. Status/Disposition of Claim:
- ☐ Closed without indemnity payment
- ☐ Settled
- ☐ Judgment/Verdict
  - ☐ For the defense
  - ☐ For the plaintiff
- ☐ Open—please provide current status and defense strategy: _____

		Paid	Reserved
Yourself	Indemnity		
	LAE (Defense)		
Codefendant(s)	Indemnity		
	LAE (Defense)		
TOTAL	Indemnity		
	LAE (Defense)		

8. Has there been a change in practice as a result of this claim(s)? ☐ Yes ☐ No
If yes, what has been the change? _____
_____
_____

I understand this information is part of my Application.

Please print your name _____

Signature _____ Date _____