Integris Assurance Company
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Glastonbury, CT 06033
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Advanced Practice Professionals
Professional Liability Application

To apply for this coverage, the applicant must be employed by an Integris Assurance Company insured physician/physician group

Application for:

- Nurse Practitioner/Advanced Practice Registered Nurse (NP/APRN)
- Physician Assistants (PA)
- Certified Registered Nurse Anesthetists (CRNA)
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)

I. PERSONAL INFORMATION

Name of Applicant:

First: _____ Last Name: _____ Middle Initial: _____ Professional Designation: _____

DOB: _____ Gender: ☐ M ☐ F

NPI Number (if applicable): _____ Specialty (if applicable): _____

Home Address:

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Email: _____

Mailing Address:

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Primary Office Address:

Employer/Group Name: _____

Address: _____

_____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Office Manager: _____

Email: _____

Billing Address (if different than Mailing address):

Address: _____

_____

City: _____ State: _____ Zip Code: _____

II. PROFESSIONAL INFORMATION

Profession (choose one):

☐ Nurse Practitioner/Advanced Practice Registered Nurse (NP/APRN)
(Note: Connecticut requires separate limits of liability)
☐ Physician Assistant (PA)
☐ Certified Registered Nurse Anesthetists (CRNA)
☐ Registered Nurse
☐ Licensed Practical Nurse (LPN)
☐ Other (please describe): _____

Name of Employer/Medical Specialty: _____ Employment Date: ____/____/____

Address of Employer: _____ Telephone Number: ____/____/____

List below all locations where you practice (please include name and address):

_____ Hours/Week: _____

_____ Hours/Week: _____

_____ Hours/Week: _____

Desired Effective Date of Coverage: ____/____/____ Desired Retroactive Date (if applicable): ____/____/____

Limits of Liability:

☐ Shared Limits of Liability

☐ Separate Limits of Liability ☐ Claims Made

Desired Limits of Liability (Check one choice):

☐ **Florida** ☐ $100K/$300K ☐ $250K/$750K ☐ $500K/$1.5M ☐ $1M/$3M

☐ **Georgia** ☐ **North Carolina** ☐ **Oklahoma** ☐ $1M/$3M

☐ **Texas** ☐ $100K/$300K ☐ $1M/$3M ☐ Other _____

**Other limits subject to Underwriting review and approval*

(Note: if Modified Claims Made, the APP will follow the same policy type of the groups/physicians)

List each state where you are licensed to practice, license number and percentage in each state:

State	License/Certification Number	Percentage

Name of your national certifying organization: _____

List all professional associations in which you are currently a member: _____

Specify the training, educational programs, internships or clinicals you have completed in order to practice in your field:

Program, Internship, Clinical Rotation	Date Completed

Please attach a copy of your Curriculum Vitae (Resume)

III. UNDERWRITING INFORMATION

(If yes, to questions 1 through 23, please provide additional information including loss estimates or payment amounts on a separate sheet. Please sign and date the information)

1.	Do you now or have you ever had any chronic physical defect or any mental or emotional illness or disorder which impaired or could impair your practice to any degree?	☐ Yes	☐ No
2.	Do you now or have you ever been treated for, or recommended for treatment of alcoholism, sexual addiction, anger management or drug addiction?	☐ Yes	☐ No
3.	Have you ever been charged with, pled guilty to, or convicted of a criminal offense?	☐ Yes	☐ No
4.	Have you ever had a complaint filed against you by any hospital, society or regulatory board?	☐ Yes	☐ No
5.	Have you ever had any professional license/permit investigated, suspended, revoked, restricted, voluntary surrendered, or placed under probation?	☐ Yes	☐ No
6.	Have you ever had any malpractice claims?	☐ Yes	☐ No
7.	Are you aware of any circumstances that might reasonably lead to such a claim or suit even if you believe the possible claim or suit would be without merit?	☐ Yes	☐ No
8.	Has any insurance company ever canceled, declined to issue or refused to renew your insurance, or offered Professional Liability Insurance only on special terms?	☐ Yes	☐ No
9.	Do/will you work at a separate location where there is no physician physically present?	☐ Yes	☐ No
10.	Has there been a change in your practice or specialty in the last five years?	☐ Yes	☐ No
11.	Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession?	☐ Yes	☐ No

12. Do you order or perform diagnostic tests?	☐ Yes	☐ No
13. Do you discriminate between normal and abnormal findings in a history, physical examination, and diagnostic tests and initiate referrals and consultations when needed?	☐ Yes	☐ No
14. Do you prescribe, regulate or adjust medications?	☐ Yes	☐ No
15. Do you prescribe, regulate or adjust treatments?	☐ Yes	☐ No
16. Do you perform a physical examination?	☐ Yes	☐ No
17. Do you conduct informed consent discussions?	☐ Yes	☐ No
18. Describe procedures, treatments, or duties you perform: _____		
19. *Are you required to maintain a written collaborative agreement and, if so, do you have one in place?	☐ Yes	☐ No
20. **Do you administer regional anesthesia such as major nerve blocks, epidural or spinal under the direct supervision of an anesthesiologist who is physically present in the room with the patient?	☐ Yes	☐ No
21. **Do you administer anesthesia in an office, surgical center, or other non-hospital setting?	☐ Yes	☐ No
22. If applicable, describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice: _____	☐ Yes	☐ No
23. Do you moonlight (perform work using your license outside control of your employer)?	☐ Yes	☐ No

IV. CLAIMS INFORMATION

24. Are you or have you been involved in a malpractice claim or suit, either directly or indirectly? If yes, please indicate total number of claims and suits: ____Open ____ Closed A Claim Addendum may be requested for open claims or suits.	☐ Yes		☐ No
25. Have all claims and suits been reported to your current or prior professional liability carrier?	☐ Yes	☐ N/A	☐ No
26. Are you aware of any of the following circumstances regarding medical care you provided:			
A. A letter or request for records from a patient or a patient's attorney or representative related to an adverse outcome from care you provided to a patient?	☐ Yes		☐ No
B. A statement by or letter from a patient or patient's representative expressing dissatisfaction or questioning the quality or timeliness of any care you provided to a patient?	☐ Yes		☐ No
C. A statement by or letter from a patient or patient's representative claiming a failure to provide care on your part or failure to diagnose?	☐ Yes		☐ No
D. Intra- or post-procedural complications or other treatment complications resulting in death, paralysis, loss of body part or bodily function, disability, re-operation or extended hospitalization or other morbidity?	☐ Yes		☐ No
E. Any death (expected or otherwise), neurological, sensory, or systematic deficits of a patient including but not limited to brain damage, permanent paralysis, loss of sight or hearing, loss of limb, or other morbidity from care you provided whether or not you believe that medical standards of care were met?	☐ Yes		☐ No
F. Any permanent damage related to an injury during delivery of child or administration of anesthesia?	☐ Yes		☐ No
G. Has a patient, patient's representative or representative filed any compliant or grievance to any healthcare institution, institution at which you practice and/or managed care organization of which you are a member, regarding care you provided to a patient?	☐ Yes		☐ No
H. Has a patient, patient's representative or any healthcare institution filed any governmental report (including Department of Public Health, and other state or federal agency) or grievance regarding care you provided to a patient?	☐ Yes		☐ No
I. Has your care ever been the subject of a peer review, sentinel event report or other investigation by any healthcare institution?	☐ Yes		☐ No
J. Are you aware of any expression of dissatisfaction with the outcome of a procedure, treatment or diagnosis performed or made by you whether from a patient or a patient's family or representative?	☐ Yes		☐ No
27. Have all circumstances that might reasonably lead to a medical incident report, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current or prior professional liability carrier?	☐ Yes ☐ None to Report		☐ No

V. COMMENTS:	
Section / Question	**Explanation**

VI. ASSIGNMENT OF POLICY RIGHTS

I assign to my employer or professional entity the right to cancel my policy and/or change my coverage terms and to receive any unearned premium due to policy changes for which my employer has paid the premium (e.g., termination of coverage, limit decrease, etc.).

This may be revoked by me at any future time by sending written notice to Integris Assurance Company.

Initial Here: _____

VII. WARRANTY: PRIOR KNOWLEDGE OF FACTS/CIRCUMSTANCES/SITUATIONS

For Alaska, Florida, Georgia, Kansas, Kentucky, Maine, Nebraska, New Hampshire, North Carolina, Oklahoma, Oregon, Virginia, Washington, and West Virginia residents ONLY: the title of this section and any other reference to "WARRANTY" is deleted and replaced with "Applicant Representation."

No person or entity proposed for coverage is aware of any fact, circumstance or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage: NONE, or except

_____

Without prejudice to any other rights and remedies of the Company, the Applicant understands and agrees that if any such fact, circumstance or situation exists, whether or not disclosed in response to this section, any claim or action based on, arising from, or in consequence of such fact, circumstance, or situation is excluded from coverage under the proposed policy, if issued by the Company.

VIII. DECLARATIONS, FRAUD WARNINGS AND SIGNATURES

The **Applicant's** submission of this Application does not obligate the Company to issue, or the **Applicant** to purchase, a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** hereby authorizes the Company to make any inquiry in connection with this Application.

The undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and in any attachments or other documents submitted with this Application are true and complete. The undersigned agree that this Application and such attachments and other documents shall be the basis of the insurance policy should a policy providing the requested coverage be issued; that all such materials shall be deemed to be attached to and shall form a part of any such policy; and that the Company will have relied on all such materials in issuing any such policy.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a Claim or potential Claim.

Notice to Alabama and 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 and may be subject to fines and confinement in prison.

Notice to Arkansas, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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 and 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 Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

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 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 and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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 Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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.

VII. DISCLOSURE AUTHORIZATION:

Please read the following carefully, then sign and date the application in the space provided below.

I HERBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the question asked. I AGREE to notify Integris Assurance Company (the "Company") promptly of any material changes in the information I have provided herein. I UNDERSTAND that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes thereto between Integris Assurance Company and any and all hospitals where I have privileges or any other institution to which the Company provides a Certificate of Insurance for the purpose of confirming my coverage (including their employees, officers, agents, directors and other representatives). This authorization does not create any obligation for the Company to release or exchange such information.

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made by me herein (and their employees, officers, agents, directors and other representatives) to release such information to the Integris Assurance Company ("Company") and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues.

I AUTHORIZE the Company and such representatives to use a copy of this authorization in place of the original. This authorization shall be valid for one year from the date signed. I understand that upon request, I (or a person authorized on my behalf) am entitled to receive a copy of this authorization.

Signature of Applicant:

Print Name: _____ Title: _____ Date: _____

Signature: _____

Signature of Agent or Authorized Representative:

Print Name: _____ License #: _____ Date: _____

Signature: _____ Company: