APPLICATION

FOR

MEDICAL ENTITY

PROFESSIONAL LIABILITY POLICY

OCCURRENCE FORM

EmPRO Insurance Company

1800 Northern Boulevard

Roslyn, New York 11576

516-365-6345 / www.myempro.com

EmPRO INSURANCE COMPANY

MEDICAL PROFESSIONAL ENTITY - APPLICATION FOR INSURANCE

Please type or print clearly

1. Date coverage to be effective: _____

2. Entity Name: _____

3. List any other names used by entity: _____

_____

_____

4. Type of entity: ☐ Professional Corporation

☐ Professional Service Limited Liability Partnership

☐ Professional Service Limited Liability Company

☐ General Partnership (of physicians)

5. Jurisdiction where formed: ☐ New York ☐ Other (specify)

6. Date of formation or authorization to operate in New York: _____

7. Principal Office Address: _____ 7a. Telephone No: _____

_____ 7b Fax No: _____

_____ 7c Email: _____

Unless otherwise specified, this will be the mailing address.

8. List all other locations: _____ _____

_____ _____

_____ _____

9. Total number of employees: _____

10. The following information must be provided for **all** licensed personnel that participate in providing professional services. Attach additional sheets as necessary.

Name: _____

Profession (e.g., physician, physician assistant, nurse practitioner, etc.): _____

Position – check all that apply: ☐ Officer (list title) ☐ Shareholder/member/owner

☐ Employee ☐ Independent contractor

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New York State Dept. of Education License No: _____

Specialty: _____

Board Certified: ☐ Yes ☐ No ☐ Not Applicable

Primary Professional Liability Insurance: Company: _____

Policy Number: _____

Policy Limits: _____

Policy Period: _____

Coverage type: ☐ Claims-Made ☐ Occurrence

Excess Professional Liability Insurance: Company: _____

Policy Number: _____

Policy Limits: _____

Policy Period: _____

Coverage type: ☐ Claims-Made ☐ Occurrence

Name: _____

Profession (e.g., physician, physician assistant, nurse practitioner, etc.): _____

Position – check all that apply: ☐ Officer (list title) ☐ Shareholder/member/owner

☐ Employee ☐ Independent contractor

New York State Dept. of Education License No: _____

Specialty: _____

Board Certified: ☐ Yes ☐ No ☐ Not Applicable

Primary Professional Liability Insurance: Company: _____

Policy Number: _____

Policy Limits: _____

Policy Period: _____

Coverage type: ☐ Claims-Made ☐ Occurrence

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Excess Professional Liability Insurance: Company: _____

Policy Number: _____

Policy Limits: _____

Policy Period: _____

Coverage type: ☐ Claims-Made ☐ Occurrence

Name: _____

Profession (e.g., physician, physician assistant, nurse practitioner, etc.): _____

Position – check all that apply: ☐ Officer (list title) ☐ Shareholder/member/owner

☐ Employee ☐ Independent contractor

New York State Dept. of Education License No: _____

Specialty: _____

Board Certified: ☐ Yes ☐ No ☐ Not Applicable

Primary Professional Liability Insurance: Company: _____

Policy Number: _____

Policy Limits: _____

Policy Period: _____

Coverage type: ☐ Claims-Made ☐ Occurrence

Excess Professional Liability Insurance: Company: _____

Policy Number: _____

Policy Limits: _____

Policy Period: _____

Coverage type: ☐ Claims-Made ☐ Occurrence

PLEASE NOTE: Physicians, nurse practitioners, physician assistants, nurse midwives, nurse anesthetists, dentists, podiatrists, chiropractors, psychologists, oral surgeons and specialist assistants are not insured as individuals under the medical professional entity policy and must maintain the individual professional liability insurance identified above. You must submit a copy of the declarations page for each person identified above.

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Coverage Options*:*

11. Limits of Liability

- ☐ $1,000,000 per claim/$3,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$4,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$5,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$6,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$7,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$8,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$9,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$10,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$11,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$12,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$13,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$14,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$15,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$16,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$17,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$18,000,000 Annual Aggregate
- ☐ $1,000,000 per claim/$19,000, 000 Annual Aggregate
- ☐ $1,000,000 per claim/$20,000,000 Annual Aggregate

12. EmPRO offers only Occurrence Coverage.

Occurrence Coverage protects you against any claim arising during your policy period irrespective of when the claim is reported.

13. List all persons identified in item 10 for whose acts or omissions the entity is requesting coverage:

_____

_____

_____

_____

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14. You must appoint a policy administrator authorized to receive all communications, make requests and give instructions on behalf of the entity:

Name: _____

Title: _____

Address (mailing) _____

_____

_____

Phone: _____ Fax: _____

E-mail: _____

15 List all professional entities under common ownership or control and for which coverage is desired.

_____

_____

16. Number of annual outpatient visits, treatments, and revenue: _____

17. Number of projected annual outpatient visits, treatments and revenue in the next 12 months: _____

*Visits- use a threshold count. Count each patient each time the patient seeks health related services

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the COMPANY to issue coverage.

This application shall be deemed appended to and a part of any policy of insurance issued to me based on this application.

My signature on this application shall be deemed to be a concurrent execution of the attached Subscriber's Agreement of Physicians' Reciprocal Insurers ("PRI"). I understand that in order to maintain my status as a policyholder of EmPRO Insurance Company, I must maintain my status as a subscriber of PRI. Termination of either contract shall result in the automatic termination of the other.

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.

Signature: _____ Date: _____

Print Name and Title: _____