



Application

Physician Assistants

Nurse Practitioners

Professional Liability Insurance

EmPRO INSURANCE COMPANY

Home Office: 1800 Northern Boulevard
Roslyn, New York 11576

Telephone: (516) 365-6345 (833) 774-6625
Fax: (516) 684-2365

Rochester Office: 1200C Scottsville Road, Suite 195
Rochester, New York 14624

Telephone: (585) 328-8860 (800) 329-8860
Fax: (585) 328-8686

PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY

PLEASE PRINT or TYPE all information and make sure all questions are answered in full.

Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.

If you have had claims or suits filed against you, please make certain you have a completed claims information form for each open suit or closed suit in the past 10 years.

Upon acceptance of your application you will be notified of premium due. Upon payment of the premium, your policy will become effective.

**FOR ASSISTANCE, APPLICANT MAY CALL OUR HOME OFFICE
AT ANY ONE OF THE NUMBERS LISTED ABOVE.**

**PROFESSIONAL LIABILITY POLICY APPLICATION
TO: EmPRO INSURANCE COMPANY**

APPLICATION FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Please note: Coverage is available on an Occurrence basis only

1. Applicant's Full Name: _____ Birth Date: _____

Applicant's Maiden Name: _____

Male Female

a) Home Address: _____

b) Home Phone Number: _____

c) Practice Location: _____

d) Phone Number: _____ Email Address: _____

2. If my application is approved, make coverage effective on _____ if possible, otherwise on any other date set by the COMPANY.

3. Physician Assistant Nurse Practitioner

License Number: _____

*** Please attach copy of registration with application.**

4. a) Social Security Number: _____

5. Education and Practice

What P.A./N.P. training program did you attend?

Name

City/State/Country

Year Graduated: _____

6. Practice/Insurance Information

Indicate rate for which you are applying:

- _____ Full Time
- _____ Part Time (requesting coverage for 20 hours total or less a week)
- _____ Locum Tenens (per diem rate for substitution for another Insured)
- _____ New Practitioner (new to private practice)

If you have checked (b) above, please complete the following regarding any practice outside of the location for which you are applying for coverage:

Name and Address of Location No. of Hours worked per week Insurance Carriers

7. List all locations where you have practiced in the last 10 years:

Street City State From/To

- a) _____
- b) _____
- c) _____
- d) _____

8. List malpractice coverage for past 10 years:

<u>Name of Carrier</u>	<u>Dates Covered</u> <u>From / To</u>	<u>Limits of Liability</u>	<u>Claims Made</u> <u>or Occurrence</u>	<u>Number of</u> <u>Claims</u>
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- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

9. Governmental Action

a. Has any governmental agency **ever** investigated, suspended, revoked, or taken any other action against either your narcotic license, your license to practice or your registration?

Yes No

If yes, explain in Remarks, #

b. Have you **ever** been convicted of a crime? Yes No

If yes, explain in Remarks, #

10. Health

Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?

Yes No

If yes, explain in Remarks, #

If yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

11. Claims or Suits

Have you **ever** been named as a defendant in a malpractice claim or suit, or are you presently involved in malpractice litigation?

Yes No

If yes, submit a separate form for each case in the last 10 years (see page 8).

12. The following statement summarizes the supervisory relationship I have with my physician employer.

___ My employing physician is physically supervising me at all times.

___ My employing physician is physically supervising me except when I am making house calls.

___ My employing physician is supervising me by phone or beeper. I am always able to get in touch with my employing physician.

13. We ask that you delineate below the duties you will perform in your role as physician assistant or nurse practitioner.

While employed by _____, EmPRO insured.

14. What is the supervising physician's method for evaluating the quality of care by the Nurse Practitioner or Physician's Assistant?

Signature, EmPRO Physician
Insured

Policy No.

Signature, Physician Assistant
or - Nurse Practitioner

15. Remarks:

16. You may appoint a policy administrator authorized to receive all communications, make requests and give instructions on your behalf with regards to your policy, except for consenting to settlement of a claim if such consent is required by the policy. Please identify the policy administrator by completing the below:

Name: _____

Title: _____

Address (mailing) _____

Phone _____

Fax _____

E-mail _____

I understand that in order to underwrite professional liability insurance, the COMPANY must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice, which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the COMPANY pursuant to this consent and direction, together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

I understand and agree that, if I am approved as a policyholder of the COMPANY and a policy issued to me, that there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.

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 to the COMPANY with this application.

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 containing any 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: _____

Please check box if you are submitting electronically only.

I fully understand that by checking this box I am accepting the terms and conditions stated above.

CLAIM INFORMATION:

1. Name of Patient: _____
2. Age: _____
3. Sex: _____
4. Allegation and your relationship to patient

5. Date of Incident: _____
6. Location: _____
7. Insurance Carrier: _____
8. Other Defendants: _____
9. Present Status: Open Claim _____
 Closed Claim _____ Loss \$ _____ Date Closed
 Settlement _____ Judgment _____
10. Condition and diagnosis at time of incident:

11. Dates and description of treatment rendered:

12. Condition of patient subsequent to treatment and DATES OF FOLLOW-UP
TREATMENT

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 VIOLATION.

Signed: _____ Date Signed: _____