EMPRO INSURANCE

HEALTHCARE PROVIDER PROFESSIONAL LIABILITY APPLICATION

AGENCY/PRODUCER: _____

PLEASE ATTACH A COPY OF YOUR CURRICULUM VITAE (CV) AS PART OF THIS APPLICATION

APPLICANT INFORMATION

Last Name	First Name	M.I.	Gender	Date of Birth	NPI Number

Email Address	Social Security Number	DEA License Number

Practice Name(s) *(Legal Name, DBA, etc)*	Practice Website	Phone Number

Practice Address *(Attn:, Street Address, City, State, Zip)* *(Check Applicable)* ☐ Mailing ☐ Billing

Residence Address *(Street Address, City, State, Zip)* *(Check Applicable)* ☐ Mailing ☐ Billing

Please attach any other relevant practice, mailing or billing addresses on a separate sheet.

EDUCATION & LICENSURE

School of Graduation *(Name of School, State/Province, Country)*	Type of Degree	Graduation Date *(Month/Year)*
Internship *(Name of Institution)*	Specialty	Graduation Date *(Month/Year)*
Residency *(Name of Institution)*	Specialty	Graduation Date *(Month/Year)*
Fellowship *(Name of Institution)*	Specialty	Graduation Date *(Month/Year)*

Which professional organization(s) are you a member of? ☐ AMA ☐ State Medical ☐ County Medical (list counties): _____ ☐ Other: _____

Please complete the following chart based on your medical license(s) and services provided (attach a separate sheet if necessary):

State	License Number	% of Practice	Services Provided

COVERAGE INFORMATION

Requested Effective Date: _____ Limits of Liability: Per Claim: _____ / Annual Aggregate: _____

Coverage Type: ☐ Occurrence ☐ Modified Claims Made ☐ Claims Made Retroactive Date: _____

How many hours do you work? (Please include direct patient care, consulting, medical records)

- Number of hours: _____/week or _____/month
- If you work part-time, when did you start working part-time? _____

Are you covered by the Federal Tort Claims Act? If yes, please complete and submit **APP 024 – FTCA Restricted Coverage** ☐ Yes ☐ No

Are you looking for moonlighting coverage only? If yes: ☐ Yes ☐ No

- Number of hours worked outside of your primary place of work: _____/week or _____/month
- Name and location of primary practice: _____

Do you have other professional liability insurance? If yes, **please attach a copy of your declarations page or certificate of insurance.** ☐ Yes ☐ No

- Carrier: _____ Limits of Liability: Per Claim: _____ / Annual Aggregate: _____
- Professional Services Covered: _____

PRACTICE ACTIVITIES

Type of Practice:

☐ Post-graduate
- ☐ Intern ☐ Resident ☐ Fellow

☐ Individual

☐ Locum Tenens

☐ Solo Corporation

☐ Member of a Group Practice* Name of Practice: _____

☐ Employee of a Healthcare Facility Name of Facility: _____

*For corporation coverage, please complete **APP 008 – Partnerships & Corporations.**

PRACTICE ACTIVITIES (continued)

Medical Specialty/Subspecialties:

Are you certified by an approved specialty board? If yes, please attach a copy of the certificate(s).

☐ No ☐ Yes Specialty: _____

Please describe any procedures or practice activities that are non-standard to your specialty:

Have your practice, employment and/or procedures changed in the past five (5) years? If yes, please explain below, including the dates of changes:

Do you perform surgery?

☐ **No Surgery** Applies to both general practitioners and specialists who do not perform obstetrical procedures or surgery (other than the incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia), and do not ordinarily assist in surgical procedures.

☐ **Minor Surgery** Applies to general practitioners and specialists who perform minor surgery or assist in major surgery on their own patients.

☐ **Major Surgery** Applies to general practitioners and/or specialists who perform major surgery or assist in major surgery on patients other than their own.

If you are performing minor or major surgery, where are the surgical procedures performed? In the office, hospital or surgi-centers?

Location: _____

If you are an orthopedic surgeon, do you perform spinal surgeries?	☐ Yes	☐ No
Do you perform childbirth deliveries? If yes, how many babies do you deliver annually? _____	☐ Yes	☐ No
Do you perform C-sections or VBACs?	☐ Yes	☐ No
Do you assist with C-sections? ☐ Own patients ☐ Other than own patients	☐ Yes	☐ No
Do you normally staff an emergency room? If yes, how many hours per month? _____	☐ Yes	☐ No
Do you participate in medical research, clinical trials or off-label use of drugs or devices? (If yes, please attach a description.) For clinical trials, please complete **APP 040 Clinical Trials Addendum.**	☐ Yes	☐ No
Do you participate in telemedicine activity? (If yes, please attach a description of the services.)	☐ Yes	☐ No
Do you provide services at a correctional facility? If yes, what percentage of your practice are these services? _____	☐ Yes	☐ No
Do you provide pain management services?	☐ Yes	☐ No
If yes, what treatment or modality do you use to treat pain? Please attach a separate sheet if necessary. _____		
Do you serve as a medical director? List where, and attach a copy of your contract. _____	☐ Yes	☐ No
Do you practice Home Health Care?	☐ Yes	☐ No
Do you practice in a Long-Term Care Facility?	☐ Yes	☐ No

EMPLOYEES AND ADDITIONAL INSUREDS

Please record the number of providers you **employ** below:

- Physicians: _____ - Surgeons: _____ - Certified Nurse-Midwives: _____

Please record the number of providers that you **supervise** below:

- Nurse Practitioners: _____ - Certified Registered Nurse Anesthetists: _____ - Medical Assistants: _____
- Physician Assistants: _____ - Advanced Practice Nurses: _____ - Other: _____

To have any of these employees covered under a separate limit of liability, please complete one or more of the following applications:

- **COV MPL 001 PS Healthcare Provider Professional Liability Application**
- **APP 002 Dentist Provider Professional Liability Application**
- **APP 009 Certified Nurse-Midwife Provider Professional Liability Application**
- **APP 026 Employee Limit of Liability Application**
- **APP 045 Allied Healthcare Provider Professional Liability Application**

CLAIM HISTORY

PLEASE ATTACH A COPY OF CURRENT LOSS RUNS

If you answer Yes to any of the following, please attach a separate sheet describing the circumstances, claim(s) or incident(s):

Have you ever had a claim?	☐ Yes	☐ No
Do you know of any pending claim(s) or incident(s) including any request for patient records that may lead to a claim?	☐ Yes	☐ No
If any incident(s), have these been reported to your current insurance carrier?	☐ Yes	☐ No

PRIOR COVERAGE INFORMATION

Attach a copy of your current professional liability insurance declarations page and copies of certificates of insurance for all hospitals where you have/had admitting privileges along with the name and address of anyone who required you to furnish them with proof of insurance.

List your prior coverage information for a minimum of the last 15 years. Start with the most recent and attach additional sheets, if necessary.

Insurer / Carrier	Dates of Coverage *(MM/DD/YYYY)* to	Policy Number	Annual Premium
Limits of Liability Per Claim / Annual Aggregate	Select Coverage Type: ☐ Occurrence ☐ Modified Claims Made ☐ Claims Made Retroactive Date:________		
States Covered	Any claims? ☐ Yes ☐ No	If Claims Made, was a reporting endorsement (tail coverage) purchased? ☐ Yes ☐ No ☐ Please provide a quote for Prior Acts coverage	

Insurer / Carrier	Dates of Coverage *(MM/DD/YYYY)* to	Policy Number	Annual Premium
Limits of Liability Per Claim / Annual Aggregate	Select Coverage Type: ☐ Occurrence ☐ Modified Claims Made ☐ Claims Made Retroactive Date:________		
States Covered	Any claims? ☐ Yes ☐ No	If Claims Made, was a reporting endorsement (tail coverage) purchased? ☐ Yes ☐ No ☐ Please provide a quote for Prior Acts coverage	

Insurer / Carrier	Dates of Coverage *(MM/DD/YYYY)* to	Policy Number	Annual Premium
Limits of Liability Per Claim / Annual Aggregate	Select Coverage Type: ☐ Occurrence ☐ Modified Claims Made ☐ Claims Made Retroactive Date:________		
States Covered	Any claims? ☐ Yes ☐ No	If Claims Made, was a reporting endorsement (tail coverage) purchased? ☐ Yes ☐ No ☐ Please provide a quote for Prior Acts coverage	

SUPPLEMENTAL INFORMATION

If you answer Yes to any of the following, please attach a separate sheet describing the circumstances:

Have you ever had any of the following revoked, denied, suspended, voluntarily surrendered, modified or restricted in any way? (Missouri residents – do not answer)

- Medical license? ☐ Yes ☐ No
- Federal narcotic license? ☐ Yes ☐ No
- Hospital staff or similar privileges while under investigation or as a result of an investigation? ☐ Yes ☐ No
- Membership in a professional society while under investigation or as a result of an investigation? ☐ Yes ☐ No

Have you ever been reviewed by a peer board pursuant to a disciplinary investigation against you? ☐ Yes ☐ No

Have you ever had a complaint filed against you by any State Board of Medicine? ☐ Yes ☐ No

Have you ever been reviewed by the DEA due to prescribing practices? ☐ Yes ☐ No

Have you ever had or been diagnosed/treated for alcoholism, narcotics addiction, or mental illness? ☐ Yes ☐ No
If yes, please provide a current letter from your treating physician and rehabilitation establishment outlining dates of and results from treatment, and current status.

Do you currently have any physical or illness limitations that could interfere with your practice of medicine? ☐ Yes ☐ No

Have you ever had any civil or criminal charges made against you by any state or federal authority? ☐ Yes ☐ No

Have you ever been convicted of any criminal act, or been found responsible for any civil complaint, filed by any state or federal authority? ☐ Yes ☐ No

Have you ever had medical professional liability insurance refused, canceled, or non-renewed? (Missouri residents – do not answer) ☐ Yes ☐ No
If yes, please advise of the company, date, and reason for this action on a separate sheet.

APPLICANT SIGNATURE

Please sign below. An additional signature is required on the State Disclosure Addendum. Your application is not complete without both signatures.

Signature	*Printed Name*	*Title*	*Date*

THIS APPLICATION SHALL BE DEEMED APPENDED TO AND A PART OF ANY POLICY OF INSURANCE ISSUED TO YOU BASED ON THIS APPLICATION.

YOUR SIGNATURE ON THIS APPLICATION SUBSCRIBES YOU TO MEMBERSHIP IN THE RECIPROCAL EXCHANGE OF PHYSICIANS' RECIPROCAL INSURERS ("PRI"), THE PARENT COMPANY OF EMPRO INSURANCE COMPANY, AND ALL OF THE BENEFITS OF THE EXCHANGE AND SHALL BE DEEMED TO BE A CONCURRENT EXECUTION OF THE ATTACHED SUBSCRIBER'S AGREEMENT OF PRI. SUBSCRIBERSHIP BEGINS WITH THE COMMENCEMENT OF THE POLICY PERIOD OF THE LIABILITY INSURANCE POLICY ISSUED BY EMPRO AND ENDS UPON CANCELLATION OR OTHER TERMINATION OF THAT POLICY.