



Paramedical Health Care Provider Professional Liability Application

Each question of this application is material and must be completed in detail. If a question does not apply, please indicate accordingly. If additional space is needed, please use the Additional Remarks Section at the end of the application.

Section I - Employers Information

Name of Employer (Entity Name)	Employers Advocate, MD MMAP Policy Number
Name of Supervising Physician (First, Middle, Last)	
Employers Signature Required	
My signature below verifies that I request coverage for the Paramedical Provider listed in Section II, to be added to my individual or group claims-made professional liability coverage policy with the Advocate, MD Medical Malpractice Availability Plan I understand that coverage will be provided, as requested in Section III, with an additional premium charge, for which I will be responsible. Further, I understand that coverage is limited to the Paramedical Provider's duties as my employee.	
_____ Employers Signature	_____ Date

Section II - Personal Information

Name of Applicant (First, Middle, Last)		Designation
Date of Birth	Place of Birth	Social Security Number

Check the one that applies:

- | | |
|---|---|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Surgeon Assistant |
| <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Certified Nurse Practitioner |
| <input type="checkbox"/> Psychologists | <input type="checkbox"/> Emergency Medical Technician |
| <input type="checkbox"/> Perfusionists | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Certified Nurse Anesthetists | <input type="checkbox"/> Cytotechnologist |
| <input type="checkbox"/> Optometrist | <input type="checkbox"/> Podiatrists |
| <input type="checkbox"/> Other | |

For Agent's Use Only (If applicable)

Name of Agency: _____	Name of Agent: _____
Address: _____	Phone Number: _____
Signature: _____	Date: _____
Are you licensed as a property/casualty insurance agent by the Mississippi Department of Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No License Number: _____ Renewal Date: _____
Do you have active Errors and Omissions Insurance Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No Policy Number: _____ Policy Term: _____ to _____

Section III – Claims-Made Coverage Selection

Important: Coverage offered by the Advocate, MD Medical Malpractice Availability Plan is written on a claims-made form. Coverage will not apply to any medical incident, as defined by the Company, which occurred prior to the coverage effective date. Failure to obtain Reporting Coverage/Tail Coverage from your expiring carrier may leave you without complete coverage.

Upon cancellation of this claims-made policy it is necessary to purchase either Prior Acts Coverage from your new carrier or Reporting Coverage from the Advocate, MD Medical Malpractice Availability Plan, if separate limits of liability are obtained.

1. Requested Effective Date of Coverage: _____ (12:01 a.m. Standard Time)
 Month Day Year

Important: Coverage will become effective only after the completion of all underwriting functions, acceptance by the Company, and receipt of the appropriate payments.

2. Coverage Limit Sought

- \$1,000,000 each medical incident/\$3,000,000 annual aggregate
- \$500,000 each medical incident/\$2,000,000 annual aggregate

3. Shared/Separate Limit of Liability Basis

- Shared Limit of Liability (sharing in the individual limits of liability of employer (s))
- Separate Limit of Liability

4. Type (select one)

- Private/Group Practice
- Political Subdivision or Employee of Political Subdivision

Section IV - Practice Locations

Primary Practice Address (Street, City, State, Zip Code)		
County	Primary Practice Phone Number	Primary Practice Fax Number
Home Address (Street, City, State, Zip Code)		
County	Home Phone Number	Home Fax Number
Secondary Practice Address (Street, City, State, Zip Code)		
County	Secondary Practice Phone Number	Secondary Practice Fax Number

Section V - Medical Training

Name of School(s) Attended	Location	Degree	Date Graduated

Section VI - Insurance History

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date and Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

1. Have you ever practiced without professional liability coverage? Yes No
2. Has your professional liability coverage ever been written with a non-admitted carrier? Yes No
3. If previously insured on a claims-made form, have you ever failed to obtain Extended Reporting Coverage? Yes No
4. Have you ever had your request for coverage denied, your policy cancelled or non-renewed or had a policy issued to you than contained restrictions or special exclusions? Yes No
5. Are you engaged in moonlighting activities?
If yes, do you have other professional liability insurance for the work that you perform elsewhere?
If yes, is coverage desired for moonlighting activities? Yes No
 Yes No
 Yes No

If the answer to questions 1 - 5 above is "Yes", please provide dates and explanations below:

Section VII - Practice Information

List all states where you are licensed/certified:

State	Type	License/Certificate Number	% of Patients seen, examined or treated in each state
Mississippi			

1. To what extent are you supervised? _____	

2. Do you practice at a location geographically separate from your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Brief description of your duties: _____	

4. Number of hours of continuing medical education completed in the past two years: _____ hours.	

List all locations where you have practice in the last five years.	Start Date and End Date (m/y)

Please provide the name and location of all hospitals where you hold active staff or courtesy privileges. Indicate below if you want a Certificate of Insurance issued to these facilities, on your behalf.

Name	Complete Mailing Address	Nature of Privileges	Certificate Desired? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

1. How many scheduled patients do you see per week? _____
2. How many walk-in patients do you see per week? _____
3. How many hours do you work per week? _____
4. In the past 5 years, has there been a change in the type of your practice? Yes No
5. In the past 5 years, has there been a change in the number of hours you work per week? Yes No
6. Are you subject to the Federal Tort Claims Act? Yes No
7. Do you provide services to Medicaid recipients, State and School Employees Health Insurance Program participants and Children's Health Insurance Program participants? Yes No

Section VIII - Rating Information

1. Do you ever work in an operating room? Yes No
2. Do you ever work in an emergency room? Yes No
3. Do you perform surgery? Yes No
4. Do you assist in surgery? Yes No
5. Do you write prescriptions?
6. Are you under contract in any capacity involving the practice of medicine? Yes No
7. Do you practice in or staff an urgent care center, walk-in urgi-center or similar minor emergency clinic? Yes No
8. Are you employed full time by the Federal Government or are you in active duty in the military service? Yes No
9. Do you practice any forms of alternative medicine, including chiropractic, holistic, Chinese, naturopathic, Homeopathic, ayurvedic? Yes No
10. Do you practice in or staff a hospital, sanitarium, or clinic with regular bed and board facilities? Yes No
11. Do you practice in or staff a surgery center, facility, laboratory, or other outpatient facility? Yes No
12. Do you treat or review treatment of any state, local federal correction facility, jail or prison? Yes No
13. Do you provide services to any nursing home or similar facility? Yes No
14. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation or reprimand ever been invoked? Yes No
15. Has your license or certification ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation or reprimand ever been invoked? Yes No
16. Have you ever been evaluated, recommended for treatment, diagnosed with, treated, or received medication for: alcohol or narcotics dependency, any other substance abuse, sexual addiction, or a mental, physical, or emotional condition? Yes No
If yes, have you had a relapse following your initial treatment? Yes No

- 17. Have you ever been asked to participate in or have you volunteered to participate in an impaired healthcare provider program? (If yes, please attach a copy of your recovery plan) Yes No
- 18. Have you ever been denied a license or certification? Yes No
- 19. Have you ever been accused of sexual misconduct of any kind? Yes No
- 20. Has a patient or his representative ever filed a complaint or grievance against you with a hospital committee, state licensing or regulatory agency or other medical review committee? Yes No
- 21. Other than a minor traffic offense, have you ever been indicted for, charged with, convicted of, pled guilty to, or entered into a plea agreement for a violation of any law or ordinance? Yes No
- 22. Have you had any injury, illness, or other event occur that may impair, lessen or diminish diminish your physical or mental ability to practice medicine? Yes No
- 23. Have you ever appeared before, been investigated by, (including ongoing investigation) or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? Yes No
- 24. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees or has your ability to participate been revoked, suspended, placed on probation or voluntarily surrendered? Yes No

If the answer to questions 1 -24 above is "Yes", provide detailed explanation below.

Section IX - Loss Information

- 1. Are you now, or have you ever been involved, directly or indirectly in a claim, potential claim, or a suit arising out of the rendering or failing to render professional services? Yes No
 - If "Yes"
 - A. Indicate number closed, dropped, dismissed _____
 - B. Indicate number pending or open _____
 - C. Total number of cases (A+B) _____
 - If "Yes," Have all claim/suits indicted in "C" above been reported to your current or prior professional liability carrier? Yes No
- 2. Other than those claims/suits indicated in question 1 above, do you have knowledge of any incident, potential claim, suit, or circumstances that might reasonably lead to a claim or suit being brought against you arising out of the rendering or failing to render professional services? Yes No
 - If "Yes" How many? _____
 - If "Yes" Have all circumstances that might reasonably lead to a 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 No

Important: For each loss indicated in questions 1 and 2 above 1) you are required to complete the attached Supplementary Loss Information Form and 2) A 5-Year Carrier Loss Run is needed from your current and/or previous professional liability carrier(s). The Loss Run should include date of occurrence, date of report, description, indemnity amount paid, indemnity amount reserved, defense amount paid, defense amount reserved and current status.

Additional Remarks Section

Please Read and Sign

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS COMPLETE, ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MISREPRESENTATIONS IN THIS APPLICATION MAY RESULT IN CANCELLATION OR RESCISSION OF COVERAGE. I FURTHER AGREE TO REMIT PREMIUMS FOR COVERAGE IN A TIMELY MANNER TO THE ADVOCATE, MD MEDICAL MALPRACTICE AVAILABILITY PLAN AND UNDERSTAND THAT FAILURE TO PAY SUCH PREMIUM IN A TIMELY AGREED MANNER MAY RESULT IN CANCELLATION OF COVERAGE.	
_____	_____
Applicant Signature	Date

Application Checklist:

- Copy of most current Professional Liability Declarations Page
- Five-year Company Loss History
- Copy of Mississippi License/Certification
- Curriculum Vita
- Job Description
- Supplemental Loss Information for each loss
- Signature and Date on Application
- Certification Form
- Verification of Extended Reporting Coverage, if applicable
- Supervising Physician Agreement, if applicable

Return Application to the Underwriting Department at:

**Advocate, MD
811 Barton Springs Road
Suite 800
Austin, TX 78704
Phone: 888-239-2501
Fax: 512-275-1240**

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section IX - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only Suit threatened, no action taken Suit filed but dropped by claimant
- Summary judgment in your favor Jury verdict in your favor Jury verdict in favor of the plaintiff
- Suit settled out of court Suit filed awaiting mediation Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section IX - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only Suit threatened, no action taken Suit filed but dropped by claimant
- Summary judgment in your favor Jury verdict in your favor Jury verdict in favor of the plaintiff
- Suit settled out of court Suit filed awaiting mediation Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____