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PARAMEDIC PROFESSIONAL LIABILITY

1. General Information

Proposed Effective Date: _____

Applicant is (check all that apply): Registered Nurse (RN), First Year Graduate Registered Nurse (RN),
 Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Aides Assistants
 Nurse Practitioner (NP) Clinical Nurse Specialist (CNS) (with prescriptive or medical diagnostic authority)
 CNS (without prescriptive or medical diagnostic authority) Other: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: () _____ Fax: () _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

2. Business Information

Detailed description of business activities (specifically, and by location): _____

How many years have you been in business? _____

Indicate how you operate (please check all that apply):

An Individual (Full Name): _____

A Solo Corporation – Name of Corporation: _____

Any dba's or trade names? If yes, please list: _____

A Shareholder of a Medical Corporation – Name of Corporation and Names of other Shareholders: _____

A Partner in a Medical Partnership – Name of Partnership and Name(s) of Partner(s): _____

A Professional Association – Name of Professional and Names of Associates: _____

An Employer – Name of Employer (Please specify if employed by an Individual, Corporation, Partnership, IPA, HMO): _____

An Independent Contractor – Name of Individual, Corporation or Partnership with whom you contract: _____

Sharing office space and/or expenses only – Names of Associates: _____

Are you practicing as part of any affiliation not noted in question 4? If yes, please explain: _____

Do you employ, contract with or supervise any other healthcare providers? Yes No

If yes, please explain: _____

Name of licensed physician with whom you collaborate. _____

If not, please indicate your referral relationships. _____

Annual Payroll: \$ _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? Yes No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: () _____

Fax: () _____ Years with Company: _____

Employee's Responsibilities: _____

Does your practice comply in every way with the rules, regulations, guidelines and standard as set forth by your State Regulatory Board? Yes No

If no, please explain in detail any non-compliance issues (attach additional pages if necessary to provide all details): _____

3. Insurance History (REQUIRED- Attach a five year loss/claims history, including details.)

A. Who is your current insurance carrier (or your last if no current provider)? _____

B. Have you been non-renewed or cancelled by another carrier? Yes No
 If yes, list the carrier and explain when, why including all details (please provide an additional page if necessary): _____

C. Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$
Policy Limits			

D. Have you had any incident, event, occurrence, loss, or wrongful act which might give rise to a claim, lawsuit or loss? Yes No
 If yes, please explain (provide an additional page if necessary): _____

E. Has the Applicant or anyone on the Applicant's behalf, attempted to place this risk in standard markets? Yes No
 If the standard markets are declining placement, please explain which carriers and why: _____

F. If you carry malpractice insurance, please mark where coverage exists? Ground Medical Transport
 Rotor Wing Medical Transport Fixed Wing Medical Transport Hospital

G. Has any insurance carrier ever declined, surcharged, rated-up, restricted, cancelled or refused to renew your medical malpractice insurance? Yes No
 If yes, please explain (provide an additional page if necessary): _____

H. Has the Applicant or any predecessor or related person or entity ever had a malpractice claim, suit or incident? Yes No

Desired Insurance

Limit of Liability (with per person sub-limit):

- \$25,000 per person / \$50,000 per accident / \$100,000 aggregate
- \$50,000 per person / \$100,000 per accident / \$300,000 aggregate
- \$100,000 per person / \$250,000 per accident / \$500,000 aggregate
- \$250,000 per person / \$500,000 per accident / \$1,000,000 aggregate
- Other: _____

Limit of Liability (with no per person sub-limit):

- \$50,000 per accident / \$100,000 aggregate
- \$100,000 per accident / \$300,000 aggregate
- \$250,000 per accident / \$500,000 aggregate

Self-Insured Retention (SIR): \$1,000 (Minimum) \$1,500 \$2,500 \$5,000 Other: _____

Note: Higher SIRs will generally reduce the premium charged, but SIRs of \$2,500 or greater must be accompanied by proof of the Applicant's ability to pay that SIR amount (i.e. last year's tax return forms).

4. Business Activities

A. Professional Designation

- Neonatal/Pediatric Transport, Pre-Hospital Care, Community Health, Critical Care Transport,
- Critical Care/ICU Emergency Room, Hospital, Air Medical Transport, Maternal & Child,
- Ground Medical Transport Pediatric Transport, Other _____

B. Describe in detail the regular operations and services you provide: _____

C. Estimated Number of patient visits per week: _____

D. Estimated Number of hours worked per week: _____

E. State Certification or License: Primary State _____ License No.: _____

Date Issued: _____ Expiration Date: _____ DEA Number: _____

NREMT License No. _____ Expiration Date: _____

Other States Licensed: _____

List states, number and date

F. Person providing accounting and tax services:

a. Name: _____

b. Address: _____

G. Are you seeking:

- a. Insurance to cover work performed exclusively by you? Yes No
- b. Insurance to cover work done by others under your direction? Yes No
- c. Insurance to cover the actions of individuals on your payroll? Yes No

H. Employee breakdown (if applicable)—please enter the number of:

	Full-Time	Part-Time
Operational Staff		
Non-Operational employees (drivers, collectors, supervisors, etc.)		

I. List all Hospitals (name and location) where you have or are applying for staff privileges. _____

J. Have you ever applied for admitting privileges and been turned down? Yes No

K. REQUIRED- Attach a copy of your risk criteria.

L. Do you have transfer agreements with any hospitals? Yes No

If yes, please identify all in detail (attach additional pages if necessary to provide all details): _____

M. Do you have a physician write orders? Yes No

N. Do you have prescriptive privileges? Yes No

O. Do you supervise students? Yes No

6. Medical Training/Education

Please include a current copy of your curriculum vitae (CV) and a copy of your practitioner/associate certificate.

Attaching a CV does not preclude the need to fully complete this application.

Institution/Program:

NAME OF INSTITUTION _____ CITY/ STATE _____ COUNTRY _____

DEGREE /CERTIFICATION _____ From: _____ To: _____
 MONTH/YR MONTH/YR

Other:

NAME OF INSTITUTION _____ CITY/ STATE _____ COUNTRY _____

DEGREE /CERTIFICATION _____ From: _____ To: _____
 MONTH/YR MONTH/YR

7. Work History

A. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.) **Please account for all time since training. Please explain any gaps in your education or profession practice history.**

Name of Employer	City	State	From: Mnth/Yr	To: Mnth/Yr

8. Additional Underwriting Information

If not applicable, please note with a N/A.

A. Have you ever been convicted of a crime (felony or misdemeanor)? Yes No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

B. Have you ever suffered from or been treated for substance abuse, mental illness or serious health or physical condition? Yes No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

C. Have you ever had a complaint filed against you with an State Regulatory Board? Yes No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

D. Have you ever had any professional license/permit or narcotics license investigated, suspended, revoked, restricted or placed on probation? Yes No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

E. Have you ever been warned about your performance or placed on any type of probation during your training? Yes No
If yes, please provide details (attach additional pages if necessary to provide all details): _____

F. Do you elicit record and evaluate a health, psychosocial and developmental history of the patient? Yes No

G. Do you perform a physical examination? Yes No

H. Describe in detail the techniques and instrument used (attach additional pages if necessary to provide all details): _____

I. Do you order or perform appropriate diagnostic tests? Yes No
If yes, please provide details (attach additional pages if necessary to provide all details): _____

J. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referral and consolation when appropriate? Yes No

Please provide details to your response (attach additional pages if necessary to provide all details): _____

K. Do you have any medical-related duties or practice activities that are insured elsewhere or for which you do not desire coverage? Yes No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

L. Do you provide weight loss treatment or diet therapy? Yes No
If yes, please provide details (attach additional pages if necessary to provide all details): _____

M. Do you provide healthcare services to correctional facilities?

Yes No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____

Dated: _____

Applicant:

Agent/Broker:

Signature

Signature

Print Name

Print Name