FOR OFFICE USE ONLY

PREMIUM:
RATED BY:
EFFECTIVE DATE:
RETRO DATE:
REFUND AMOUNT DUE:

ALLIED WORLD
A FAIRFAX Company

Allied World Insurance Company ("Insurer")

Return and make checks payable to:
American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694

RENEWAL APPLICATION FOR OCCURRENCE-BASED NURSE PRACTITIONER/ REGISTERED NURSE/ PHYSICIAN ASSISTANT/ADVANCED PRACTICE REGISTERED NURSE PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants:
License # L045052 issued to Peter Imbert

Notice to Iowa Applicants:
License # 3000928232 issued to Peter Imbert

Notice to California Applicants:
License # 0555091 issued to Peter Imbert

NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION V. (C). "MAXIMUM LIMIT OF LIABILITY - SEXUAL MISCONDUCT" IN THE POLICY).

- This Application must be completed in full, including all required attachments. Write "None" if that applies.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant's needs.

PLEASE READ THE ENTIRE RENEWAL APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. a. Name of Applicant _____ License No.: _____

Date of Birth: _____

Phone No.: ( ) _____ E-mail address: _____

b. Professional Designation (check one):
☐ Nurse Practitioner ☐ Physician Assistant
☐ Advance Practice Registered Nurse
☐ NP Student (Educational Program _____)
☐ Other

c. Coverage desired (check one):

☐ Individual ☐ Partnership ☐ Professional Corporation (Incorporated as a P.C. or P.A.) ☐ LLC/LLP
☐ General Business Corporation ☐ Profit ☐ Nonprofit ☐ Other (Please explain) _____

(If you are unsure of your corporate status, please check your Articles of Incorporation or other business documents.)

If you have checked anything other than "Individual" in response to 1 c., the following MUST BE INCLUDED: (1) a copy of articles of incorporation; (2) a letter describing all services provided; (3) any brochures if available; and (4) a listing of owners and/or partners, indicating the percentage of the business owned by each

II. APPLICANT INFORMATION

HAVE ANY OF YOUR RESPONSES TO QUESTIONS 2. THROUGH 5. BELOW CHANGED? IF NO, PLEASE GO TO QUESTION 6.

2. a. Principal Office Address: _____

_____

(City) (County) (State) (Zip)

Entity and/or Facility Name: _____

b. Any Other Office Address: _____

_____

(City) (County) (State) (Zip)

Entity and/or Facility Name: _____

c. Home Address: _____

_____

(City) (County) (State) (Zip)

3. To which of these addresses do you wish correspondence sent? ☐ 2a ☐ 2b ☐ 2c

4. Office Telephone: ( ) _____ Home Telephone: ( ) _____

5. a. Professional Liability Limits Requested? (CHECK ONE OPTION):

☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000 ☐ $1,000,000/$6,000,000 ☐ Other_____/_____

b. Would you like to add comprehensive cyber coverage, with base limits of $100,000?* ☐ Yes ☐ No

(No additional application is required; higher limits may be available and require separate underwriting.)

c. For group policies only:

1. Are you interested in separate limits for each named insured?* ☐ Yes ☐ No
2. Are you interested in adding Medical Director Coverage?* ☐ Yes ☐ No

d. Are you interested in obtaining General Liability limits?* ☐ Yes ☐ No

If yes, please indicate limits requested: $_____ / $_____

If you are adding general liability coverage, please indicate the location(s) where coverage is requested:

_____

e. Are you interested in obtaining limits higher than $25,000 for defense expenses related to licensing board investigations and other proceedings as described in the Policy? ☐ Yes ☐ No

If yes, choose higher limit of liability desired for defense expenses related to proceedings as described in the Policy:

☐ $50,000 (Add. Prem. $110) ☐ $75,000 (Add. Prem. $171) ☐ $100,000 (Add. Prem.$232)
☐ $125,000 (Add. Prem. $293) ☐ $150,000 (Add. Prem. $354)

*Additional premium will be required. Please contact our office for total premium due.

III. PRACTICE INFORMATION

HAVE ANY OF YOUR RESPONSES TO QUESTIONS 6. THROUGH 16. BELOW CHANGED SINCE THE COMPLETION OF YOUR PRIOR APPLICATION FOR THIS COVERAGE? ☐ Yes ☐ No

IF YES, PLEASE RESPOND TO QUESTIONS 7. THROUGH 16. IF NO, PLEASE GO DIRECTLY TO SECTION VI., QUESTION 17. OF THIS APPLICATION.

6. a. List your name and qualifications. For group practices, please provide name and qualifications of all salaried (W-2) employees, except clerical. If you require additional space, please attach a separate sheet of paper.

Name	Degree	Field of Study	Employment Status W-2, 1099, etc.	Hours Worked Per Week	License or Certification			
					First Year Licensed	State	Board Certified?	Title

Please attach a copy of a Curriculum Vitae (C.V.) for each of the above-listed practitioners.

b. Practice Area: (Please select all that apply)

☐ RN/ NP Student
☐ OB/GYN, OB/GYN Acute Critical Care Advanced Practice Nurse
☐ Psychiatric / Mental Health Advanced Practice Nurse
☐ Pediatric / Family Acute Critical Care (No OB/GYN)
☐ Community Health / Maternal & Child
☐ Medical-Surgical
☐ Neonatology
☐ School Advanced Practical Nurse
☐ Neurology
☐ Cosmetic Procedures
☐ Doula
☐ Other _____

7. Are you a current active member of any professional association? If yes, please list association(s): _____

_____

IV. PRACTICE CHARACTERISTICS

8. a. Are you engaged in (check all that apply):
☐ Self-Employment ☐ Paid Consultation (1099 form) ☐ Volunteer Work

b. Are you employed (W-2 form employee)? ☐ Yes ☐ No

If yes, employed by: _____

c. Do you own, partly own, manage or exercise any form of fiduciary control over any business enterprise or medical practice? ☐ Yes ☐ No

If yes,

i. Please explain the nature of the enterprise. _____

ii. Please provide a count of employees by type. _____

9. a. Are you self-employed? ☐ Yes ☐ No If No, please answer questions 9. b-h

b. Name of physician, hospital, clinic or practice you will be working for:

_____

c. Insurance carrier/limits: _____ Name of supervising physician: _____

d. Clinical specialty area of your supervising physician: _____

e. Will you be working at the same location as your supervising physician? ☐ Yes ☐ No

If no, where will you be working? _____

f. Do you have a written collaboration agreement with your supervising physician? ☐ Yes ☐ No

g. How often will your charts be reviewed? _____

h. Do you have written practice protocols? ☐ Yes ☐ No

If you are both self-employed and a W-2 employee, and wish to apply for part-time self-employed coverage, a separate statement indicating that you are fully insured by your employer at your W-2 employment must be submitted.

☐ ***I understand that if I apply and qualify for the exclusively employed rate, the policy will exclude coverage for any work performed outside of my employment which includes, but is not limited to, private practice, self-employment, consulting, volunteering and any other activities outside of the course and scope of my employment.***

10. Do you have medical diagnostic and prescriptive authority? ☐ Yes ☐ No

If yes to prescriptive authority, what Schedule? _____

If no, please provide the name and clinical specialty of the physician who will write prescriptions:

_____

11. Do you use any Independent Contractors or Consultants (1099 form) whose services are in the healthcare field and who you do billing for, share fees with or in any way derive income from the relationship? ☐ Yes ☐ No

If yes, please list the name and professional credentials for each on the following page.

All Independent Contractors or Consultants (1099 form) must be listed. You will be covered for their acts subject to the terms of the policy, but the Independent Contractor or Consultants listed will not be insureds under the policy.

Name of Independent Contractor or Consultant	Degree	Field of Study	License or Certification	
			State	Title

If additional space is required, please use a separate sheet of paper to submit a complete listing.

12. Has any person or entity, based on a contractual obligation, requested that they be added to your policy as an Additional Insured? ☐ Yes ☐ No

If yes, name of the proposed Additional Insured: _____
Address of proposed Additional Insured: _____

a. The proposed Additional Insured is my:
☐ Employer ☐ Landlord ☐ Professional Corporation ☐ Other (Specify): _____

b. The proposed Additional Insured gives me the following form to file with the IRS:
☐ W-2 form ☐ 1099 form ☐ Other (Specify):_____

c. Describe the relationship between you and the proposed Additional Insured: _____

13. a. Are you on the staff of, or affiliated with, any hospital, clinic, group home or nursing home? ☐ Yes ☐ No
If yes, please list institution, nature of work and hours per week. _____
_____

b. Are you covered by any other malpractice policy? ☐ Yes ☐ No
If yes, please indicate policyholder name, relationship, insurance carrier and limits. _____
_____

c. Do you have any direct or indirect financial interest in any hospital, pharmacy, diagnostic or therapeutic laboratory, nursing home, health service or any healthcare service to which you refer your patients?
☐ Yes ☐ No
If yes, please specify and fully explain._____
_____

V. PRACTICE PROFILE

14. Please answer the following questions regarding your practice:

a. Do you have admitting privileges? ☐ Yes ☐ No

If no, please describe your mechanism for handling your patients who may require immediate in-patient care:

_____

b. Average number of patients seen on an annual basis: _____

c. Who creates and updates medical records for each patient you see in the practice? _____

d. What medical record system is used in your practice? _____

e. Do you obtain an informed consent, whether signed by the patient or noted in the chart, before prescribing medication? ☐ Yes ☐ No

f. Do you cover any ER for crisis cover? ☐ Yes ☐ No

If yes, please indicate percentage of time devoted to this activity: _____%

Is this on call? ☐ Yes ☐ No

If yes, approximately how many hours per week? _____

15. Does your practice include telemedicine activities, e.g. the transfer of data through electronic (video or computer) means to provide healthcare to patients who are geographically separated from the clinicians involved? ☐ Yes ☐ No

a. What is the total practice time devoted to this activity? _____%

b. Is the system used to provide these activities encrypted and HIPAA compliant? ☐ Yes ☐ No

16. Do you engage in any clinical trials and/or pharmaceutical research? ☐ Yes ☐ No

If yes, does the sponsor agree in writing to indemnify you for such research activities? ☐ Yes ☐ No

(Please include a copy of these indemnification agreements)

If no, please explain type and extent of such activities: _____

VI. REPRESENTATIONS

17. a. Have you ever been convicted of a crime in any state or country or are you currently under indictment or under investigation for any crime? ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered. _____

_____

b. Have you ever had any licensing board or professional ethics body investigate you/your practice or enter a finding, formal or informal, of a violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐ Yes ☐ No

If yes, please give full particulars and provide copies of charges, correspondence and any findings in order for your Application to be considered._____

_____

c. Have you been contacted in the last year by any licensing board or professional ethics body or are there any complaints, charges or investigations, formal or informal, pending against you by a licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence, or negligence in any state or country? ☐ Yes ☐ No

In the past year have you been contacted by any representative for one of the above organizations related to your conduct? ☐ Yes ☐ No

If yes, please give full particulars and copies of charges, correspondence, and any findings in order for your Application to be considered._____

_____

d. Have you ever had any insurance company or Lloyd's decline, cancel, refuse to renew, or accept only on special terms any professional liability insurance? ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered._____

_____

e. Has any professional liability claim or suit ever been made against you? ☐ Yes ☐ No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your Application to be considered. _____

_____

_____

f. Are there any circumstances which you are aware of that may result in any professional liability claim or suit being made against you? This would include any loss of private or confidential information or unauthorized dissemination of same. ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered._____

_____

_____

g. Have you engaged in or ever been engaged in any sexual misconduct* with any of your current or former patients, or any current or former patient's spouse or any person with a direct relationship to the current or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?

(*"Sexual misconduct" means any actual or alleged erotic physical contact or attempt, threat or proposal thereof, whether electronically or in person.) ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered._____

_____

h. Have you ever had any hospital restrict or revoke privileges or invoke probation for any cause? ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered. _____

_____

i. Have you ever been suspended, restricted, or put on probation by any governmental health program (i.e. Medicare or Medicaid)? ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered. _____

_____

_____

j. Are you now being, or have you ever been, treated for a serious health problem that did or can impair your ability to treat patients? ☐ Yes ☐ No

If yes, please give full particulars in order for your Application to be considered. _____

_____

VII. NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation.

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

VIII. DECLARATION AND SIGNATURE

I understand that it is my obligation to maintain any license required in the jurisdictions in which I practice.

Date:_____ Signature:_____
(This application must be dated within 30 days of receipt) (APPLICANT / OWNER / PRESIDENT OF CORPORATION)

Title:_____

Application must be signed, dated, fully completed and accompanied by the premium to be considered.

Please make checks payable and mail to: American Professional Agency, Inc.

Program Administrator:
AMERICAN PROFESSIONAL AGENCY, INC.
95 Broadway, Amityville, NY 11701
(631) 691-6400 • (800) 421-6694
www.americanprofessional.com

Producer Signature:

Save form first on your computer before submitting.

American Professional Agency, Inc.
95 Broadway, Amityville, NY 11701
(631) 691-6400 – (800) 421-6694

CLAIM ACTIVITY

Be sure to answer all question fully, leave no blanks.

a) Name of claimant or plaintiff:_____
(Last) (first) (Middle)

Age:_____ Sex:_____ Marital Status:_____

b) Date of alleged incident:_____

c) Location of incident (Hospital, office, clinic, etc.) :_____

d) Issue or type of injury claimed: - What was the objective issue contested in this claim ?

Injury: ☐ Emotional Only ☐ Cosmetic ☐ Temporary Disability ☐ Permanent Disability ☐ Death

Diagnosis:_____

Prognosis:_____

Prior Treating Physicians:_____

Subsequent Treating Physicians:_____

_____

e) Were other physicians or hospitals involved as co-defendants ? ☐ No ☐ Yes Please list names: _____

_____

f) Name of insurance company defending you: _____

g) Was claim or suit: ☐ actually brought against you ☐ merely threatened, or ☐ limited to claimants attorney contact?

h) Disposition of claim:

☐ Abandoned (no activity over 3 years)

☐ Won by defense

☐ Judgement or verdict vs. co-defendant(s) only

☐ Settled ☐ won by claimant. If so, how much was paid on your behalf? _____

_____

☐ Open (State Current Status) _____

Narrative Description of Incident _____

_____

_____

Please photocopy this form and supply us with separate information for each claim, suit or incident.
CAP-SUP (6/00)

QUARTERLY BILLING FORM

PLEASE READ THE FOLLOWING INFORMATION CONCERNING OUR QUARTERLY BILLING PROCEDURE

The following procedures will apply for accounts with premium exceeding $1,000 annually, that wish to pay in quarterly installments:

1. A bill will be issued to you 45 days prior to the due date for each quarterly payment.

2. Since we are required to give you advanced notice that your coverage will lapse if payment is not received, a notice will be sent stating that if payment is not received your policy will be cancelled on the date indicated on the cancellation notice. This is required state insurance regulations and also serves as a reminder that payment has not been received.

3. If a notice of cancellation is sent out and payment is then received prior to the cancellation date, a letter voiding out the cancellation will be provided to you.

I wish to make my payments in installments. I have remitted 35% of the annual premium.

I understand that I will be billed for the remaining quarters and a $5.00 service charge will be included in each quarterly bill. A $20.00 service charge will be assessed to each quarterly payment which is returned for uncollected funds.

E-mail address: _____

Signature: _____ Date:_____

IMPORTANT SURCHARGE INFORMATION
Allied World Insurance Company

NOTICE TO FLORIDA RESIDENTS:

The Florida Insurance Guaranty Association requires insurance companies to charge all policies written for its residents a surcharge of 1%. Please include this additional premium when remitting your premium.

NOTICE TO KENTUCKY RESIDENTS:

Kentucky law requires insurance companies to charge all policies written for its residents a surcharge of 1.8%. Depending on your profession, we may be required to assess your policy with a municipality tax which is based on the location of your residence. Please include this additional premium when remitting your premium.

NOTICE TO MAINE RESIDENTS:

The Rural Medical Access Program requires insurance companies to charge physicians, hospitals, and physicians' employers who are insured for professional liability through a licensed insurer to pay the assessment of .4% to the insurer upon the insurers' premium billing. This charge applies to policyholders who are Psychiatrists, Psychiatric NPs, Physician Assistants, Neurologists, Nurse Practitioners, APRNs, and CNSs with prescriptive authority.

NOTICE TO NEW JERSEY RESIDENTS:

The New Jersey Property and Liability Insurance Guaranty Association requires insurance companies to charge all policies written for its residents a surcharge of .3%. Please include this additional premium when remitting your premium.

NOTICE TO WEST VIRGINIA RESIDENTS:

West Virginia law requires insurance companies to charge all policies written for its residents a surcharge of .55%. Please include this additional premium when remitting your premium.