



FOR OFFICE USE ONLY

PREMIUM:

RATED BY:

EFFECTIVE DATE:

RETRO DATE:

REFUND AMOUNT DUE:

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 California Applicants:  
License # 0555091 issued to Peter Imbert

Notice to Iowa Applicants:  
License # 3000928232 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<br>W-2, 1099,<br>etc. | Hours Worked<br>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 or agreement to bind insurance.

**NOTICE TO NEW YORK APPLICANTS:** "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 SUCH VIOLATION."

## 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.**



Producer Signature:

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

*Save form first on your computer before submitting.*

**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 \_\_\_\_\_

## **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.