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

APPLICATION FOR OCCURRENCE-BASED NURSE PRACTITIONER/REGISTERED NURSE/ PHYSICIAN ASSISTANT/ADVANCED PRACTICE REGISTERED NURSE STUDENT PROFESSIONAL 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 THE SECTION ON "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 APPLICATION CAREFULLY BEFORE SIGNING.

I. GENERAL INFORMATION

1. Name of Applicant: _____

   Date of Birth: _____

   E-mail address: _____

2. Mailing Address: _____

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

3. Office Telephone: ( ) _____ Cell Phone/Home Phone: ( ) _____
4. Policy Limits Requested (CHECK ONE OPTION):

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

5. Effective date requested: _____
6. Are you interested in increased limits of $25,000 for Damage to Property of Others (for an additional premium of $50)? ☐ Yes ☐ No

7. Education:

Name of Colleges or Universities Attended or Attending	Location of College or University (City and State)	Degrees Received or Expected upon Graduation	Date(s) Degrees were received or Expected Graduation Date	Curriculum Major

8. Are you a member in good standing of any professional association?
☐ Yes ☐ No ☐ Pending Application

If "Yes," state the association and specify the membership category: _____
☐ Regular ☐ Clinical ☐ Associated ☐ Student ☐ Other: _____

II. REPRESENTATIONS

A POLICY WILL BE ISSUED BY THE INSURER TO THE APPLICANT BASED ON THE FOLLOWING REPRESENTATIONS.

9. If you answer "Yes" to any of the following questions, please include all documents pertinent to the situation you are describing.

a. Has the Applicant ever been charged with or convicted of a crime in any state or country? ☐ Yes ☐ No

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

_____

_____

b. Has the Applicant ever had any licensing board or professional ethics body investigate 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. Are there any complaints, charges or investigations, formal or informal, pending against the Applicant 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

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

_____

_____

d. Has the Applicant 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 the Applicant? ☐ 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 the Applicant is aware of that may result in a professional liability claim or suit being made against the Applicant? 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. Is the Applicant 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. _____

_____

_____

III. NOTICES TO APPLICANT

The undersigned 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."

IV. SIGNATURE

Signature of Applicant: _____
(Student)

Print Name: _____

Date: _____

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.
If you wish to pay by credit card, please contact this office for details.

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.

Producer Signature:

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)

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.