111 East Shore Road, P.O. Box 4300
Manhasset, New York 11030

Phone

| | |
|---|---|
| Brooklyn, Queens, Staten Island | (718) 895-6033 |
| Nassau & Suffolk | (516) 365-6690 |
| New York City | (212) 936-3050 |
| Toll Free | (800) 632-6040 |
| Fax No. | (516) 365-6039 |


# APPLICATION FOR CERTIFIED REGISTERED NURSE ANESTHETISTS

**PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY**

**PLEASE PRINT** or **TYPE** all information and make sure all questions are answered in full.

Incomplete or missing answers will cause delays in processing and may cause coverage to be declined.

If you have had claims or suits filed against you, please make certain you have a completed claims information form for each claim or suit in the past 10 years.

Upon acceptance of your application you will be notified of premium due. Upon payment of the premium, your policy will become effective.

**FOR ASSISTANCE, APPLICANT MAY CALL OUR HOME OFFICE AT ANY ONE OF THE NUMBERS LISTED ABOVE.**

(9/93)

**PHYSICIANS PROFESSIONAL LIABILITY POLICY APPLICATION**
**TO: PHYSICIANS RECIPROCAL INSURERS, an Exchange**

## APPLICATION FOR CERTIFIED REGISTERED NURSE ANESTHETISTS

APPLICANT MUST ANSWER ALL QUESTIONS

1. Name: ________________________________________ Birthdate: _____/____/____
   Last First Middle
   S.S. # __________________

2. Home Address: ________________________________________________
   Number & Street
   ______________________________________________________________
   City County State Zip Code

3. Name of Employer: ____________________________________________

4. Address of Employer: __________________________________________
   Number & Street
   ______________________________________________________________
   City County State Zip Code

5. Employer Practices as: _____ Individual Practitioner
   _____ Partnership
   _____ Professional Corporation

6. Name of Supervising Doctor: ____________________________________
   Name Specialty
   Telephone # ______________________
   Office

7. Applicant's professional training:

| NAME OF SCHOOL HOSPITAL, ETC. | FROM/TO (mo., day, year)(mo., day, year) | TYPE OF TRAINING | DATE OF COMPLETION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

8. a) Registration Number: ______________________________________________
* Please attach copy of registration with application.

b) If certified or registered by a professional organization, provide full name, certification or registration number and corresponding date. ________________________________

9. Has any insurance company ever cancelled or declined to renew professional liability insurance for the Applicant? _____ Yes _____ No

If "Yes", explain: ____________________________________________________
________________________________________________________________

10. Have you ever had a malpractice claim or suit (closed or pending) asserted against you?
_____ Yes _____ No.

If "Yes", state present status of each such claim or suit. Give details, which should include: name of patient, dates and description of treatment, and amount of settlement (if applicable).

________________________________________________________________
________________________________________________________________
________________________________________________________________

11. Indicate by X the Limits of Liability you wish the policy to provide.

| CHECK ONE: | LIMITS OF LIABILITY | |
|---|---|---|
| | **EACH PERSON AGGREGATE** | **GENERAL AGGREGATE** |
| _____ | 500,000 | 1,500,000 |
| _____ | 1,000,000 | 3,000,000 |

**YOU MUST MAINTAIN THE SAME LIMITS OF LIABILITY AFFORDED BY THE COMPANY TO YOUR SUPERVISING/EMPLOYING PHYSICIAN.**

12. List malpractice coverage for past 10 years:

| Name of Carrier | Dates Covered From - To | Limits of Liability | Claims-Made or Occurrence | Number of Claims -Made |
|---|---|---|---|---|

-

1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________
4. ________________________________________________________________
5. ________________________________________________________________

**RELEASE OF INFORMATION**

I hereby authorize Physicians' Reciprocal Insurers to obtain full information from any insurance company or from any person with respect to any claim or suit or incident pertaining to professional acts or omissions asserted against me. I expressly release and discharge from liability any insurance company or persons providing such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

I understand and agree that, if I am approved as a Subscriber to the Exchange and a policy issued to me, that there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.

I do hereby warrant the truth or any statements and answers mentioned herein, and that I have not withheld any information which is calculated to influence the judgment of the Exchange in considering this application for professional liability insurance.

Agreement: I understand that the policy being applied for does not cover liability of others, which I may have assumed under any contract or agreement. To assure proper protection I agree to submit a copy of such contract or agreement to the Exchange for underwriting consideration together with this application.

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant to the Exchange with this application.

I understand that in order to underwrite professional liability insurance, the Exchange must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice, which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Exchange pursuant to this consent and direction, together with the agents, employees, or offices of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

**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 VIOLATION.**

Signature ______________________________ Date ____________________

APPLICANT'S SIGNATURE

Claim Information:

1. Name of Patient ______________________________ 2. Age _____ 3. Sex _____

4. Allegation and your relationship to patient (e.g.: attending physician, primary surgeon, asst. surgeon, etc. ______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

5. Date of Incident ________________________ 6. ______________________________________

7. Insurance Carrier ______________________________________________________________________

8. Other Defendants: ______________________________________________________________________

9. Present Status: Open Claim _____
   Closed Claim _____ Loss $ ________ Date Closed ___________
   Settlement ________________________ Judgment ____________

10. Condition and diagnosis at time of incident: _______________________________________________
______________________________________________________________________________
______________________________________________________________________________

11. Dates and description of treatment rendered: _______________________________________________
______________________________________________________________________________
______________________________________________________________________________

12. Condition of patient subsequent to treatment and DATES OF FOLLOW-UP TREATMENT
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

Signed: __________________________________________ Date Signed: ________________