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APPLICATION FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

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 open suit or closed 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.**

(8/95)-(7/04)

PHYSICIANS' PROFESSIONAL LIABILITY POLICY APPLICATION
TO: PHYSICIANS' RECIPROCAL INSURERS, an Exchange
APPLICATION FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

I am applying for _____ An Occurrence Policy

1. Applicant's Full Name: _____ Birth Date: _____

Applicant's Maiden Name: _____

a) Home Address: _____

b) Home Phone Number: _____

c) Practice Location: _____

d) Phone Number: () _____

2. If my application is approved, make coverage effective on _____
if possible, otherwise on any other date set by the Exchange.

3. Physician Assistant/Nurse Practitioner

Registration Number: _____

* Please attach copy of registration with application.

4. a) Social Security Number: _____

5. Education and Practice

What P.A./N.P. training program did you attend?

Name

City/State/Country

Year Graduated: _____

Practice/Insurance Information

6. Indicate rate for which you are applying:

- (a) Full Time
- (b) Part Time (requesting coverage for 20 hours total or less a week)
- (c) Locum Tenens (per diem rate for substitution for another Insured)
- (d) New Practitioner (new to private practice)

If you have checked (b) above, please complete the following regarding any practice outside of the location for which you are applying for coverage:

Name and Address of Location No. of Hours worked per week Insurance Carriers

7. List all locations where you have practiced in the last 10 years:

Street City State During Years

- a) _____
- b) _____
- c) _____
- d) _____

8. List malpractice coverage for past 10 years:

<u>Name of Carrier</u>	<u>Dates Covered From - To</u>	<u>Limits of Liability</u>	<u>Claims Made or Occurrence</u>	<u>Number of Claims</u>
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- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

9. Governmental Action

a. Has any governmental agency **ever** investigated, suspended, revoked, or taken any other action against either your narcotic license, your license to practice or your registration?

Yes No

If yes, explain in Remarks, #

b. Have you **ever** been convicted of a crime?

Yes No

If yes, explain in Remarks, #

10. Health

Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?

Yes No

If yes, explain in Remarks, #

If yes, please submit a letter from you're treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

11. Claims or Suits

Have you **ever** been named as a defendant in a malpractice claim or suit, or are you presently involved in malpractice litigation?

Yes No

If yes, submit a separate form for each case in the last 10 years (see page).

12. The following statement summarizes the supervisory relationship I have with my physician employer.

___ My employing physician is physically supervising me at all times.

___ My employing physician is physically supervising me except when I am making house calls.

___ My employing physician is supervising me by phone or beeper. I am always able to get in touch with my employing physician.

A maximum of two registered physician assistants or certified nurse practitioners will be employed by any one physician. In instances of disagreement between the employing physician and the physician assistant or nurse practitioner, regarding the matter of diagnosis or treatment, the physician's opinion will preside. A registered physician assistant or certified nurse practitioner may perform medical services, but only when such acts and duties assigned him/her are within the scope of practice of the employing physician.

13. We ask that you delineate below the duties you will perform in your role as physician assistant or nurse practitioner.

While employed by _____, PRI insured.

In order to process your Application PRI must also receive copies of:

- Practice Agreement
- Practice Protocols

Signature, PRI Physician Insured

Policy No.

Signature, Physician Assistant
- or - Nurse Practitioner

14. Remarks: _____

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.

Signature: _____ **Date:** _____

I do hereby affirm the truth of 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.

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any 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."

Signature _____ **Date** _____

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 officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information is wrong.

Signature _____
APPLICANT'S SIGNATURE

Date _____

CLAIM INFORMATION:

1. Name of Patient: _____ 2. Age _____ 3. Sex _____
4. Allegation and your relationship to patient _____

5. Date of Incident: _____ 6. Location: _____
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:** _____