Ob-Gyn Risk Alliance

Application for Limited Professional Liability Coverage Insured Paramedical Employee

ProAssurance American Mutual

ProAssurance American Mutual, A Risk Retention Group
PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • 205.877.4400 • Fax 205.868.4040

Requested Effective Date: _____ /_____ /_____

Name (Last, First, MI): _____

SSN: _____ DOB: _____ Sex: Male ☐ Female ☐

Home Address: _____ City: _____ State: _____ ZIP: _____

Current Employer: _____ Telephone Number: _____

Business Address: _____ City: _____ State: _____ ZIP: _____

1. Profession:

☐ Physician Assistant
☐ Surgical Assistant
☐ Certified Nurse Midwife
☐ Certified Nurse Practitioner
☐ Certified Registered Nurse Anesthetist
☐ Cytotechnologist

2. Is your employer insured by a ProAssurance Company? Yes ☐ No ☐

3. Have you ever:

A. Been convicted of a criminal offense? Yes ☐ No ☐
B. Been treated for (or recommended for treatment for) alcoholism, sexual, or drug addiction? Yes ☐ No ☐
C. Undergone psychiatric treatment? Yes ☐ No ☐
D. Had a complaint filed against you with any hospital or regulatory board? Yes ☐ No ☐
E. Had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? Yes ☐ No ☐

If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. is yes, please provide complete details on a separate sheet of paper.

4. Do you moonlight (work outside control of employer)? If yes, where? Yes ☐ No ☐

_____

_____

5. Do you have your own separate practice without a collaborating physician? Yes ☐ No ☐

6. Do you hold the certification of licensure required in your state to practice your profession? Yes ☐ No ☐

If yes, where did you receive your training?

_____

7. Are you a member of any professional organization? If yes, please give details.

_____

_____

8. Have any judgments ever been rendered against you or any out-of-court settlements in excess of $500 been made on your behalf from an incident alleging professional errors or omissions? Yes ☐ No ☐

If yes, please give details on a separate sheet. If available, please enclose copy of complaint.

9. Has any action been filed against you or have you been notified that any action, regardless of dollar amount, will be filed against you alleging professional errors or omissions? Yes ☐ No ☐

   If yes, please give details on a separate sheet. If available, please enclose copy of complaint.

10. Has an insurance company that provided you medical professional liability or related coverage, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes ☐ No ☐

    If yes, please provide the reason(s) for the adverse underwriting decisions in the space provided at the end of the application.

11. Does your supervising physician regularly review medical records and cases with you? Yes ☐ No ☐

12. Is your clinical competency validated by the physician? Yes ☐ No ☐

13. Will you be scheduled to work at a separate location from your supervising physician? Yes ☐ No ☐

    If yes, please give details on a separate sheet.

14. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? Yes ☐ No ☐

15. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes ☐ No ☐

16. Do you order or perform diagnostic tests? Yes ☐ No ☐

17. Do you discriminate between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed? Yes ☐ No ☐

18. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes ☐ No ☐

19. Do you perform a physical examination?

    If yes, briefly describe techniques and instruments used: _____

    _____

20. Do you conduct informed consent discussions? Yes ☐ No ☐

21. Describe any other procedures, treatments, or duties you perform:

    _____

    _____

22. Do you provide any cosmetic procedures/services? Yes ☐ No ☐

    If yes, please indicate which procedures.

    ☐ Botox ☐ Derma Fillers ☐ Laser Hair Removal
    ☐ Microdermabrasion ☐ Laser Skin Resurfacing ☐ Sclerotherapy

23. Do you perform Deliveries as a midwife? Yes ☐ No ☐

    If yes, please answer the following questions:

    A. How many deliveries are performed annually by midwife? _____

    B. Do midwives perform induction/augmentation? Yes ☐ No ☐

    C. Do Midwives perform assisted Vaginal Deliveries? Yes ☐ No ☐

       If yes, is the physician present? Yes ☐ No ☐

    D. Do Midwives perform VBAC deliveries? Yes ☐ No ☐

       If yes, is the physician present? Yes ☐ No ☐

    E. Do Midwives perform underwater births? Yes ☐ No ☐

    F. Do Midwives perform home or birthing center deliveries? Yes ☐ No ☐

    G. As a mid-level provider do you follow alternative birthing plans? Yes ☐ No ☐

       If yes, please describe: _____

24. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:

    _____

    _____

25. Please list all states in which you are licensed along with each license number and renewal date:

State	License Number	Renewal Date

26. Please include copies of the following:
    A. Current Curriculum Vitae
    B. Copy of your approved notification of supervision form
    C. Copy of current professional liability insurance declarations page
    D. Claims history
    E. Copies of your practice protocols

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Risk Management Agreement Language

I agree that my office staff and I will comply with all Ob-Gyn Risk Alliance risk management programs administered by ProAssurance companies. Our compliance includes cooperating with ProAssurance and its employees and independent contractors in all risk management assessments and recommendations, participating in educational programming, and committing to work with the Ob-Gyn Risk Alliance to improve patient care and thus reduce losses.

I agree to ensure that my staff will work to further such risk management collaboration and comply with all education and risk management improvement recommendations.

I understand that compliance with this statement is necessary for membership in the Ob-Gyn Risk Alliance Purchasing Group, and failure to comply may jeopardize further participation in the program.

Name (Printed): _____

Applicant's Signature: _____ Date: _____

Consent to Conditions of Consideration of the Application for Insurance

I understand that no coverage will be bound until after ProAssurance has reviewed my completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, my advance payment will be promptly returned to me.

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me.

To the fullest extent permitted by law, I extend absolute immunity to and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I understand that should any incident, injury or death occur to any patient while under my care subsequent to my signing and dating this application, I must notify ProAssurance or its authorized agent or broker in writing of such event.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following section is an Applicant's Representation and Authorization from which requires your signature. Please read carefully.

Applicant's Representation and Authorization

I, the undersigned, hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon my acceptability to ProAssurance and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name and Title (Printed): _____

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

Insured Physician's Authorization

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

Requested Effective Date: _____

Shared Limits Coverage ☐

Separate Limits Coverage ☐

Note: Separate Limits Coverage is not available for Cytotechnologists.

_____ _____

Signature of Insured Physician/Supervising Physician Date

_____

Please Print Name

Proxy for ProAssurance American Mutual, A Risk Retention Group Applicants

In consideration of ProAssurance American Mutual, A Risk Retention Group's issuance of insurance to the Applicant, the Applicant hereby constitutes and appoints the Chairman of the Board of ProAssurance American Mutual, A Risk Retention Group as the Applicant's proxy to attend all meetings of the members of ProAssurance American Mutual, A Risk Retention Group, with full power to vote as proxy for the Applicant and act in the Applicant's name, place and stead, in the same manner, to the same extent, and with the same effect that the Applicant might if personally present, giving to the Chairman of the Board full power of substitution. This grant of a proxy shall continue in force indefinitely until either (1) the Applicant ceases to be a policyholder of ProAssurance American Mutual, A Risk Retention Group or (2) the Applicant revokes the proxy.

THE APPLICANT MAY REVOKE THIS PROXY AT ANY TIME BY ATTENDING A MEETING OF THE MEMBERS OF PROASSURANCE AMERICAN MUTUAL, A RISK RETENTION GROUP OR BY SENDING PROASSURANCE AMERICAN MUTUAL, A RISK RETENTION GROUP A WRITTEN NOTICE REVOKING THE PROXY.

_____
Name of Applicant

_____
Signature of Applicant or Authorized Officer

_____
Print Name

_____
Title

_____
Date