INTERSTATE
HEALTHCARE

Professional Liability Insurance for Nurse Practitioners

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1) Please print a copy of this application to your desktop printer.
2) Complete this hard copy by hand, answering all questions
3) Sign, date and either:

    a. Mail your completed application providing credit card information OR with check payable to: **Interstate Healthcare, 24150 Little Mack Ave., St Clair Shores, MI 48080**

    OR

    b. Fax your signed and completed application providing your credit card information (per the application) to Interstate Healthcare at (586) 585-1352

    OR

    c. Scan and email your completed application providing your credit card information (per the application) to chuck@medmalquotes.com

4) Once your application is processed & approved, your policy will be mailed within 5-7 business days. Your payment – whether by check or credit card – will NOT be processed until your coverage has been approved.

Fax or Mail Completed Application To:
Interstate Heatlhcare
24150 Little Mack Ave
St. Clair Shores, MI 48080
(800) 419-5999 (586) 879-6397
Fax (586) 585-1352 chuck@medmalquote.com

If previously covered with Medical Protective, please enter the policy number ___________________________

INTER

THE MEDICAL PROTECTIVE COMPANY

(a Stock Company)

HEALTHCARE PROFESSIONAL - PROFESSIONAL LIABILITY INSURANCE APPLICATION - NP

I. General Information

Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

A. ____
First Name Middle Initial Last Name

_______________ ________ ____ / ____ / ________ ______________________________ ______________
Degree (DNP/MA) Suffix Date of Birth MM/DD/YYYY Professional License Number Graduation Year

____ ____________________ ____________________
Street Address Apartment/Suite # City

_________________ ______ ___________ _______________ ______________________________
County State Zip Code State of Practice National Provider Identifier # (Optional)

______-_____-_______ ______-______-_______ _______-______-________
Business Phone Business Fax Residence/Cell Phone

E-mail Address: ____

B. Requested Effective Date: _____ /_____ /______
MM DD YYYY

II. Coverage Information

**Please note that requested policy types may not be available in all states.*

A. Coverage Desired:

___ Occurrence coverage
___ Claims-Made coverage without Prior Acts coverage
___ Claims-Made coverage with Prior Acts coverage
___ Conversion from Claims-Made to Occurrence

PLEASE CALL (800) 419-5999
FOR MORE INFORMATION OR FOR
CLARIFICATION IF NEEDED.

B. Retroactive date shown on my current Claims-Made policy is: ____ / _____ / ______
(This date is not a requirement for Occurrence or Claims-Made without Prior acts policies.) MM DD YYYY

C. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage, and the most recent prior coverage was issued on a Claims-Made basis, please mark one of the following:

__ An extended reporting endorsement (tail coverage) has been purchased.
__ An extended reporting endorsement has not and will not be purchased.

* Please be advised that if you do not purchase tail coverage (an extended reporting endorsement) from your current insurer where you are insured under a Claims-Made policy, this will result in an uninsured exposure for any claims which may arise as a result of professional services rendered or which should have been rendered while insured by your current insurer's

policy. If you do not purchase tail coverage from your current insurer, understand that the policy for which you are applying with The Medical Protective Company, if offered, will not provide prior acts coverage.

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact our office should you have any questions pertaining to the diffferences between Claims-Made and Occurence coverage.

D. Desired Limits:

** Please note that requested limits options may not be available in your state.*

__ $100,000/$300,000 __ $200,000/$600,000 __ $250,000/$750,00
__$500,000/$1,000,000 __ $1,000,000/$3,000,000 __ $1,000,000/$6,000,00
__$2,000,000/$6,000,000

III. Practice Information

A. Please indicate your Nurse Practitioner Rating Class: (Please select all that are applicable. At least one must be selected.)

N1: ☐ Dermatology ☐ Geriatric ☐ Women's Health Care ☐ Oncology ☐ Gynecology
☐ Correctional Facility < 10 hours/week

N2: ☐ Psychiatric Care

N3: ☐ Family Practice ☐ Pediatric ☐ School Nurse ☐ Neonatal Care

N4: ☐ Acute Critical Care ☐ OB/GYN ☐ Perinatal Care ☐ Cosmetic/Aesthetic ☐ Pain Management

☐ Correctional Facility > 10 Hours / Week

NS: Students currently attending an accredited Nurse Practitioner Program

**** I understand that if I am a Nurse Anesthetist or Certified Nurse Midwife, I am not covered by this policy.***

____

B. If your specialty is OB/GYN, are you responsible for the labor or delivery of a fetus? __ Yes __ No __ N/A

C. Do you perform any major invasive surgical procedures? __ Yes __ No

If yes, please give a general description: ______________________________

D. As a Nurse Practitioner I practice as: ___ Employee (W2 & not owner) ___ Self-Employed (File 1099 Tax Form)

E. Indicate the estimated average number of hours you practice per week. ______________

F. Is your professional designation/certification currently valid? __ Yes __ No

Please provide date of most recent certification: ___ / ___ / _____
MM DD YYYY

G. Highest level of education: __ Masters (MS) __ Doctorate (DNP) __ Licensed Nurse Midwife

H. Have you completed training/education courses in addition to the level required for licensing/certification?

If yes, please provide details. ______________________________

I. If you are a student, what is the anticipated date of graduation? ___ /___ /______
MM DD YYYY

J. Are you a member of a Professional Association(s)? __ Yes __ No

If yes, please list membership affiliation(s) ______________________________

K. Have you completed a risk management education course within the last (12) months? __ Yes __ No

IV. Additional Practice Information

A. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses? __ Yes __ No

If yes, please attach a separate sheet with full particulars including date(s).

B. Have you ever had your hospital privileges, DEA license, healthcare license or reimbursement privileges, refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? __ Yes __ No

If yes, please attach a separate sheet with full particulars including date(s).

C. Has any professional liability insurance company ever declined, refused, canceled or non-renewed your coverage?
____ __ Yes __ No

If yes, please indicate the date(s) and explain: Date ____ /_____ ______________________________
MM YYYY

D. Have you ever been accused of sexual misconduct of any kind? __ Yes __ No

If yes, please indicate the date(s) and explain: Date ___ /_____ ______________________________
MM YYYY

E. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics or other controlled substances, etc). __ Yes __ No

* If yes, please complete Medical Condition Supplement

V. Loss Information

Please complete the Loss Information Supplement for each written request, incident, claim or suit that has NOT been covered by a Medical Protective policy.

Report professional liability and malpractice-related matters, including but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim, or suit, received a written request for treatment records arising out of the rendering or failure to render professional services, or related to any other coverage you are requesting from Medical Protective (e.g. CGL, EPLI, etc.)**?** __ Yes __ No

If yes, how many? ______

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? __ Yes __ No

This includes, but it is not limited to, the following:

◊ Amputation ◊ Permanent Neurological Injury ◊ Loss of Major Organ Function ◊ Death ◊ Loss of Vision.

If yes, how many? _______

C. In the last 12 months, have you received a written request from an attorney for treatment records concerning any current or former patient(s) which might reasonably result in a claim or suit against you? __ Yes __ No

If yes, how many? _______

VI. Professional Liability Coverage

A. Please list your prior professional liability insurance, if any.

Insurance Carrier	Coverage Type (Occurrence or Claims-Made)	Policy Number	Limits	Effective Date(s)	Retro Date

MANDATORY: *ALL APPLICANTS must read the following*:______

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 subjects such person to criminal and civil penalties, which may include voiding of the policy if allowed by state law.

VIII. Notes and agreements

I further acknowledge that the above statements and particulars, or any statments and particulars made in any an all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments**") for the purposes of my intial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I or any applicant agree that this appliaction, and any **Attachments**, shall be the bases of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitaion, any change in professional speciality, affliation or working arrangement with any other healthcare provider, facility, firm or professional association.

Where allowed by state law, I understand that any material misrepensentaion or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to resind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

The Delaware Civil Union & Equality Act of 2011

The Medical Protective Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 including the following:

Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

Compliance with Illinois Bulletin 2011-06 and The Religious Freedom Protection and Civil Union Act

The Medical Protective Company recognizes the rights afforded to individuals under The Religious Freedom Protection and Civil Union Act which states:

"The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married." or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

____ Date Signed: ____ / ____ / ______

Applicant's Signature MM DD YYYY

____

Print Name

Agent Name & License Number (if applicable): ____

PREMIUM PAYMENT OPTIONS

PREPAYMENT REQUIRED

☐ Check or money order enclosed. ☐ Charge premium to credit card.

I authorize Interstate Healthcare to charge the premium to my: ☐ VISA ☐ MASTERCARD ☐ Discover

Credit Card Account Number:____ Expiration Month and Year: ____ / ______

Print name exactly as it appears on card:_____________________________________

THIRD PARTY CREDIT CARD AUTHORIZATION Please complete the following (if payer other than applicant):

CHARGE TO: ☐ VISA ☐ MASTERCARD ☐ Discover

Credit Card Account Number:____ Expiration Month and Year: ____ / ______

Card Member Name (Print):____

Signature:____ Date Signed:____________________

MAIL OR FAX COMPLETED APPLICATION & PAYMENT INFORMATION TO:

Interstate Healthcare
24150 Little Mack Ave., St. Clair Shores, MI 48080
(800) 419-5999 (586) 879-6397 FAX: (586) 585-1352 chuck@medmalquotes.com

THE MEDICAL PROTECTIVE COMPANY APPLICANT NAME: ____________________________

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL

LOSS INFORMATION SUPPLEMENT

Please complete the following information for each applicant involved in each claim or incident. Please make copies if additional forms are needed for multiple claims or incidents and/or each applicant.

Note: Additional documentation may be requested at The Medical Protective Company's discretion.

A. Is the matter related to A, B or C from the Loss Information section? (Check only one.)

- ☐ **A.** Current or prior claim.
- ☐ **B.** Complication, incident, or adverse outcome.
- ☐ **C.** Written request for records.

B. Is the matter identified in the Loss Information section related to (Check only one)**:**

- ☐ Professional Liability
- ☐ Other Commercial Liability, i.e. General Liability, EPLI, Cyber, etc. (please describe): ____________________________

C. Patient/Claimant Information:

______________________________ ______________________________ ______

Last Name First Name Age

D. Date of treatment and/or surgery which led, or could lead, to allegations against you: ______ / __________ (MM/YYYY)

E. Date of notice received, if applicable: ______ / __________ (MM/YYYY)

F. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If Yes, date reported to your current or former insurer: ______ / ________ (MM/YYYY)

Current or former insurer name: ____________________________

If No, please explain: ____________________________

G. Name of all other doctor(s), hospital(s), surgery center(s) or healthcare provider(s), if any, involved: ____________________________

____

H. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $ ______________________

If closed, date of closing: _____ / _________ (MM/YYYY)

Was a payment made? ☐ Yes ☐ No

1. If Yes, did you consent to the settlement? ☐ Yes ☐ No
2. Total amount of settlement or award: $ ______________________
3. Total amount of settlement or award paid on your behalf: $ ______________________

I. Nature of allegations or potential allegations:

Condition treated: ____________________________

Treatment provided: ____________________________

Alleged negligence: ____________________________

Alleged injury: ____________________________

J. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

____

____

K. What steps or procedures have you adopted to prevent a similar claim? Please explain:

____

____

Applicant's Name: ____

HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

Assignment of Cancellation Rights and Premium Refund Supplemental Application

Would you like to assign an employer or named third party the right to cancel your policy and receive any premium refund? _____ Yes _____ No

If yes, please sign below:

By my signature, I assign to the following employer or named third party (include name and address), the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all premium refund correspondence be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to CM&F Group at 212-233-8919 or sending written notice to The Medical Protective Company Program Administrator, CM&F Group, Inc. 99 Hudson Street, 12th Floor, New York, NY 10013-2815.

____
Name of Employer or Third Party

____
Street Address

____________________ ____________ ____________
City State Zip Code

(   ) ____________________
Phone #

____
Signature of Applicant

____
Date