APPLICATION FOR DESIGNTED EMPLOYEES

Please answer every question or mark it "not applicable" (N/A). Incomplete answers and/or missing attachments **will** delay our processing of the application.

Producer: ____________________

A. GENERAL INFORMATION (Please type or print clearly in ink)

1. **Name:** ____________________ (____________)
   First Middle Last Maiden

☐ RN ☐ LPN ☐ Medical Assistant ☐ Surgical Assistant ☐ Surgical Technician ☐ Other ____________

2. **Date of Birth:** ____________________ 3. ☐ Male ☐ Female

4. **Social Security Number:** ____________________ 5. **License Number:** ____________________

6. **Home Address:** ____________________ ( ) ____________
   Number Street Telephone
   ____________________ ( ) ____________
   City County State Zip Fax

7. **Email Address:** ____________________

B. PRACTICE INFORMATION

Please include any out of state locations.

1. **List all locations, other than hospitals and surgicenters, at which you currently render professional services. Include all office locations, nursing homes, urgent care clinics and other non-hospital locations. Attach additional pages if needed. FAILURE TO LIST A LOCATION MAY RESULT IN IT BEING EXCLUDED FROM COVERAGE UNDER THIS POLICY.**

   a. **Location #1 - Primary Address for which coverage is desired:**

   ____________________ ( ) ____________
   Number Street Telephone
   ____________________ ( ) ____________
   City County State Zip Fax

   Number of hours per week you are at this location: ____________
   Is this location a: ☐ Private Office ☐ Nursing Home ☐ Clinic ☐ Other (describe)

   b. **Location # 2 - Additional Address:**

   ____________________ ( ) ____________
   Number Street Telephone
   ____________________ ( ) ____________
   City County State Zip Fax

   Number of hours per week you are at this location: ____________ Coverage desired? ☐ Yes ☐ No
   Is this location a: ☐ Private Office ☐ Nursing Home ☐ Clinic ☐ Other (describe)

2. **Privileges – List all hospitals and surgicenters at which you currently have privileges or to which you are applying for privileges. Attach additional pages if needed. FAILURE TO LIST A LOCATION MAY RESULT IN IT BEING EXCLUDED FROM COVERAGE UNDER THIS POLICY.**

   a. **Facility No. 1:**

   ____________________ ( ) ____________
   Number Street Telephone
   ____________________ ( ) ____________
   City County State Zip Fax

   Number of hours per week you are at this location: ____________ Coverage desired? ☐ Yes ☐ No
   Is this location a: ☐ Surgicenter ☐ Hospital ☐ Other (describe)
   Privileges: ☐ Active Type and Extent ____________
   ☐ Pending Restrictions ____________

b. **Facility No. 2:**

_____ Number Street _____ ( ) _____ Telephone

_____ City County State Zip _____ ( ) _____ Fax

Number of hours per week you are at this location: _____ Coverage desired? ❒ Yes ❒ No

Is this location a: ❒ Surgicenter ❒ Hospital ❒ Other (describe)

Privileges: ❒ Active Type and Extent _____

❒ Pending Restrictions _____

c. **Facility No. 3:**

_____ Number Street _____ ( ) _____ Telephone

_____ City County State Zip _____ ( ) _____ Fax

Number of hours per week you are at this location: _____ Coverage desired? ❒ Yes ❒ No

Is this location a: ❒ Surgicenter ❒ Hospital ❒ Other (describe)

Privileges: ❒ Active Type and Extent _____

❒ Pending Restrictions _____

Do you want Certificates of Insurance provided to these locations? ❒ Yes ❒ No

❒ All Locations/Facilities listed, or ❒ Location 1 ❒ Location 2 ❒ Facility #1 ❒ Facility #2 ❒ Facility #3

3. **Mailing Address:** ❒ Home ❒ Primary Office ❒ Other (list below):

_____

_____

C. TRAINING INFORMATION

1. **Training Program:**

	Name	Location	From/To	Completed Y/N	Degree
Program Attended:					
Additional Training:					

D. COVERAGE INFORMATION

1. **Requested Effective Date:** _____

2. **Current or immediate past carrier:** _____ **Policy expiration date:** _____
   (Please attach a copy of your most recent declarations page.)

3. **Have you ever had professional liability insurance refused, declined, cancelled or accepted on special terms?** ***(If yes, explain in Remarks).*** ❒ Yes ❒ No

4. **List all previous insurance carriers for the past ten (10) years:**

A. Insurance Carrier ________________ Policy # ________________ Medical Specialty ____________________

Type (CM/OCC) ________________ From ______________ To ________________

B. Insurance Carrier ________________ Policy # ________________ Medical Specialty ____________________

Type (CM/OCC) ________________ From ______________ To ________________

C. Insurance Carrier ________________ Policy # ________________ Medical Specialty ____________________

Type (CM/OCC) ________________ From ______________ To ________________

D. Insurance Carrier ________________ Policy # ________________ Medical Specialty ____________________

Type (CM/OCC) ________________ From ______________ To ________________

E. Insurance Carrier ________________ Policy # ________________ Medical Specialty ____________________

Type (CM/OCC) ________________ From ______________ To ________________

E. MEDICAL CONDUCT INFORMATION

1. **Governmental Action**
   a. Has any governmental agency **ever** investigated, suspended, revoked, or taken any other action against either your narcotic license or your license to practice? *(If YES, explain in Remarks)* ☐ Yes ☐ No
   b. Have you **ever** been convicted of a crime? *(If YES, explain in Remarks)* ☐ Yes ☐ No

2. **Have you been involved in, or are you presently involved in a diversion or rehabilitation program?** *(If YES, explain in Remarks)* ☐ Yes ☐ No

3. **Health**
   Do you have any health problems, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? *(If Yes, explain in Remarks)* ☐ Yes ☐ No

4. **Claims or Suits**
   Have you **ever** been named as a defendant in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten (10) years, or are you presently involved in malpractice litigation?
   (If YES, submit a separate form for each case in the last ten (10) years, see page) ☐ Yes ☐ No

F. PRACTICE AND PROCEDURES: GENERAL QUESTIONS

1. **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.

2. **Employing Physician:** ________________________ 3. **Policy Number:** ______________________________

10671-PA (01/10)

4. **Do you prescribe and/or dispense drugs?** *(If Yes, explain in Remarks)* ❒ Yes ❒ No

5. **Do you work in an operating room?** ❒ Yes ❒ No
   If yes, do you ❒ Observe ❒ Assist ❒Other (explain):____________________

6. **Do you work in a labor and delivery room or birthing center?** ❒ Yes ❒ No
   If yes, do you perform duties under the direct physician supervision? ❒ Yes ❒ No

7. **Is the employing physician registered as a Supervising Physician with the State Board?** ❒ Yes ❒ No

8. **Do you perform ANY cosmetic procedures including, but not limited to, laser treatments, injections, weight loss/fat reduction treatments, etc.?** *(If Yes, explain in Remarks)* ❒ Yes ❒ No

9. **We ask that you delineate below the duties you will perform in your role while employed by, who is insured by the Company.**

____

____

____

____

<u>In order to process your application the Company must also receive copies of:</u>

<u>- Practice/Collaborative Agreement</u>
<u>- Practice Protocols</u>

______________________________	____________	______________________________
Signature, by the Company Physician Insured	Policy No.	Signature, Physician Assistant or Nurse Practitioner

Remarks

Question #	Answer

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

The application duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature form does not bind the applicant or the Company to issue coverage.

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 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.

I understand that in order to underwrite professional liability insurance, the company 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 Company pursuant to this consent and direction together with 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: ____ Date: ____________________

Pennsylvania Physicians' Reciprocal Insurers
1800 Northern Boulevard
Roslyn, NY 11576

Producer Affirmation: by my signature, I hereby represent that the applicant has granted me full authority to complete and/or submit this application on their behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that the applicant understands and agrees that such representation is binding upon him or her, even though I am completing and/or submitting the application on their behalf. I further acknowledge that any material misrepresentation or omission made on this application may result in the termination of my broker agreement.

PRODUCER SIGNATURE: ____ Date: ____________________

Please make additional copies of this page as necessary. If you have had claims or suits filed against you, please complete this form for each claim or suit in the past ten (10) years. Provide information on all claims that have also been resolved (closed, tried or settled) within the past ten (10) years. Also include all "incidents".

CLAIM INFORMATION

1. Name of Patient ______________________ 2. Age _____ 3. Sex ____
4. Your relationship to patient: ______________________
5. Allegation ______________________
6. **Date of incident** ____________ **7. Report date** ____________
8. Insurance carrier ______________________
9. Other defendants ______________________
10. **Present Status: ☐ Open claim ☐ Closed claim Date closed ________ Settlement or Judgment Amount ________**
11. Location of incident ______________________
12. Condition and diagnosis at time of incident ______________________
13. Dates and description of treatment rendered ______________________
14. 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: ______________________

CLAIM INFORMATION

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4. Your relationship to patient: ______________________
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13. Dates and description of treatment rendered ______________________
14. 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: ______________________