a medical professional liability risk retention group

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

For Advanced Practice Providers

INSTRUCTIONS: Please complete all sections of this form either electronically or in ink. All sections requiring a signature or initials must be signed in ink.

CHECKLIST:

- ☐ Signed, dated and fully completed application. Alternatively, you may attach an application for another insurer that you completed within the last 60 days, or attach a current CAQH report. If you submit an alternative application or report, you must still sign and date each page of this application and (i) tell us the number of hours you work each week on page 3; (ii) confirm and sign if you are declining prior acts coverage on page 4; and (iii) complete the Professional Liability History Section beginning at page 6.
- ☐ Provide a current copy of curriculum vitae
- ☐ Provide a copy of the declaration page from your current malpractice insurance policy, if applicable
- ☐ Provide a copy of your current DEA registration, if applicable
- ☐ Provide "policy history reports", "claim history reports" or "loss runs" covering the past ten years (These must be obtained from your prior insurance carrier(s) or broker(s)
- ☐ Provide a copy of your collaborative agreement, if applicable

All attachments are considered to be a part of this application.

If this is an application for a claims-made policy form of professional liability insurance, the coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services or the use of your professional office premises, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval. No coverage exists until a binder or Declarations Page, together with any endorsements that may apply, have been issued to the named insured.

Send completed application and associated documentation to:

CPP Program
Murray Securus
PO Box 1728 ♦39 North Duke Street
Lancaster, PA 17608-1728

If you have any questions regarding the application process or any information required in this application, please contact the Program Services Department at (717) 397-9600 ext. 1228.

PERSONAL INFORMATION

First Name _____ Middle Name _____ Last Name _____ Suffix _____

Degree or Title _____ Date of Birth _____ E-mail _____

Requested Effective Date of Coverage

The policy you are applying for will be 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 guaranty funds are not available for your risk retention group.

Applicant's Signature _____ Date _____

(02/19)

CPP a medical professional liability risk retention group

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

For Advanced Practice Providers

Applicant's Name _____ Effective Date of Coverage _____

PRACTICE INFORMATION

Practice Name _____ Office Phone _____

Corporate Office Address _____ Office Fax _____

City _____ State _____ Zip Code _____

LICENSURE AND CERTIFICATION

I am applying for coverage as a:

- ☐ Certified Nurse Midwife
- ☐ Nurse Anesthetist (CRNA)
- ☐ Licensed Practical Nurse
- ☐ Nurse Practitioner (CRNP)
- ☐ Nurse Surgical Assistant
- ☐ Occupational Therapist
- ☐ Optician
- ☐ Optometrist
- ☐ Perfusionist
- ☐ Physician Assistant
- ☐ Psychologist
- ☐ Physical Therapist
- ☐ Registered Nurse
- ☐ Radiology Technician
- Other: _____

PA License Number (If applicable) _____ Additional Certifications _____

WORK SETTING/HOURS

Please check all that apply:

- ☐ Primary Physician Office
- ☐ Specialty Physician Office
- ☐ Psychiatric Facility
- ☐ Emergency Department
- ☐ Trauma Center
- ☐ Nursing Home/Extended Care Facility
- ☐ Hospital Operating Suite
- ☐ Hospital In-Patient Unit
- ☐ Ambulatory Surgery Center
- ☐ Other Outpatient Facility

Average hours worked per week

Please indicate the average total hours worked per week for this practice:
(Worked hours includes patient care, hospital rounds, record-keeping, administrative duties, teaching, house-calls, nursing home visits and utilization review)

- ☐ 10 or less hours
- ☐ 11-20 hours
- ☐ 21-29 hours
- ☐ 30 or more hours

SCOPE OF PRACTICE

Please check all that apply:

- ☐ Assist in surgery
- ☐ Diagnostic management
- ☐ Ordering/interpreting diagnostic testing
- ☐ Perform physical assessments
- ☐ Compile patient histories
- ☐ Pre or post operative care
- ☐ Obstetrical care
- ☐ Prescribe medications
- ☐ Pediatric care
- ☐ Anesthesia administration
- ☐ Emergency or critical care <10 hrs per week
- ☐ Emergency or critical care >10 hrs per week
- ☐ After hours/weekend call
- ☐ _____
- ☐ _____

Applicant's Signature _____ Date _____

(02/19)

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For Advanced Practice Providers

Applicant's Name

HOSPITAL PRIVILEGES

Hospital Name	City, State	Type of Privileges	Specialty or Department

INSURANCE HISTORY

	Current Policy	First Prior Policy
Name of Carrier		
Type of policy	☐ Claims-Made ☐ Occurrence	☐ Claims-Made ☐ Occurrence
Effective date		
Expiration date		
Retroactive date		

COVERAGE REQUESTED

Type of coverage requested:

☐ Claims-Made Coverage

☐ Occurrence Coverage

Limits of Liability requested:

☐ $500,000 per claim/$1,500,000 Annual Aggregate

☐ $1,000,000 per claim/$3,000,000 Annual Aggregate*

* Certified Registered Nurse Practitioners and Physicians Assistants are required to obtain limits of $1,000,000/$3,000,000

PRIOR ACTS COVERAGE

If your prior policy is a "CLAIMS-MADE" policy, you must either purchase prior acts coverage through this policy or obtain an extended reporting period endorsement (tail) from your prior carrier.

If you DO NOT WANT or DO NOT NEED prior acts coverage, please indicate this decision by signing in the space provided. By signing, you are acknowledging that your retroactive date of coverage WILL BE THE SAME as your effective date of coverage.	I decline or do not need retroactive coverage Applicant Signature

ADDITIONAL INFORMATION

	Yes	No
Within the past seven (7) years have you been the subject of any complaint, charge or disciplinary action against you for any reason by a court, licensing board, hospital, or regulatory agency responsible for enforcing or maintaining the standards of your profession?	☐	☐
Have you ever had your professional liability insurance declined, cancelled or non-renewed for any reason?	☐	☐

Please provide a brief explanation for either question above:

Applicant's Signature

Date

(02/19)

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For Advanced Practice Providers

Applicant's Name

PROFESSIONAL LIABILITY HISTORY

Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior or current insurer?		Yes		No
Has any claim or suit for alleged malpractice been brought against you in the prior ten (10) years?		Yes		No
Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?		Yes		No

Please provide a brief explanation for each situation which requires a "YES" answer to any of the prior three questions:

1.

2.

3.

4.

The undersigned agrees to fully comply with the conditions of membership in CPPRRG and understands that noncompliance may result in a non-renewal of coverage. The undersigned declares that to the best of his or her knowledge and belief that the statements set forth herein are true. Although the signing of this application does not bind the undersigned on behalf of the applicant or its organization or other insured person to effect insurance, the undersigned agrees that this application and its attachments shall be the basis of the contract should a policy be issued and shall be attached to and form part of this policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

Notice to Pennsylvania Applicants: 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 a person to criminal and civil penalties.

The policy you are applying for will be 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 guaranty funds are not available for your risk retention group.

Applicant's Signature

Date