Hospitals Insurance Company, Inc. ("HIC")

Application for Professional Liability Insurance Coverage

Physician Extenders

("Physician Extender" means NYS Licensed/Certified Nurse Anesthetist, Nurse Practitioner, Registered Physician Assistant, Nurse Midwife or Midwife)

Please note the following:

1. Return the completed application, along with a **copy of your New York State professional license** and the **declaration page from your current insurance policy.** All questions on the application must be answered. If a question is not applicable, please write "Not Applicable."
2. Employees of HIC insured physicians are eligible for coverage.
3. Employees of a Professional Entity are eligible if directly supervised by (or in a collaborative relationship with) a HIC VAP insured.
4. Policies are issued for limits of $1,000,000 Each Person, $3,000,000 Total Aggregate.
5. Insurance coverage is provided on an "Occurrence" basis

1. Name: ____
   Last First Middle

   Mailing address: ____

   Date of Birth: ____________ Social Security Number:________________ Email:__________________

   Phone Number: _________________ Cell Phone: ____________________

   Title: Professional Designation License Number

Professional Designation	License Number
☐ Certified Midwife (CM)	__________________
☐ Certified Nurse Midwife (CNM)	__________________
☐ Certified Registered Nurse Anesthetist (CRNA)	__________________
☐ Nurse Practitioner (NP)	__________________
☐ Registered Physician Assistant (PA)	__________________
☐ Specialist Assistant (SA)	__________________

   DEA Number: ______________________________

   Desired date of coverage:________________
   (MM/DD/YY)

An ***Occurrence Policy covers*** claims brought against you because of professional services that you provided (or should have provided) in the course of your medical or surgical practice during the policy period, regardless of when the claim is made. As long as you provided (or failed to provide) those professional services during the policy period, a related claim is covered no matter when it is brought against you.

Policy will be: full-time ☐ part-time ☐ (20 hours or less per week)

Complete This Section For Part Time Policies *Only*

Use the table below to record the number of hours spent weekly in the portion of your practice to be covered by the HIC part-time policy for which you are applying. (Include all professional activity including patient care, record keeping, consultation, etc.)

Hours by Day of Week

	IN OFFICE	OTHER	FACILITY NAME(S) (Please Print)	TOTAL HOURS
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
TOTAL				

2. **PRIMARY EMPLOYER**

Name of employer: ______________________________

Employer's office address: ______________________________

Phone: ______________ Fax: ______________ Email: ______________

Employer practices as: ☐ Individual Practitioner ☐ Partnership ☐ Professional Corporation
☐ Other: ______________

HIC policy number for employer: ______________________________

Name/specialty of supervising physician: ______________________________
Name Specialty Phone

License Number: ______________________________

3. **ADDITIONAL EMPLOYERS** (if applicable):

Provide the following information for **additional** HIC insured employers you may have:

Name of employer: ____

Employer's office address:____

Phone: __________________ Fax: ____________________ Email: ________________________

Employer practices as: ☐ Individual Practitioner ☐ Partnership ☐ Professional Corporation
☐ Other: ______________________________

HIC policy number for employer:____

Name/specialty of supervising physician: ____
Name Specialty Phone

License Number: ____________________________________

(Attach additional pages if necessary)

4. **PRACTICE INFORMATION**

Do you have a license to practice outside of New York State (NYS)? ☐ Yes ☐ No

If yes, provide State(s) and license numbers: ____

Status: (Active/Inactive/Other (please specify): ____

What percentage (%) of your professional services are provided outside of NYS? __________________

Coverage is provided only for your professional services while acting within the scope of your duties for your employer(s). Should insurance coverage be issued, it is an absolute condition of the insurance policy that HIC is the insurer of your employer(s), and that such insurance remain in full force and effect for the full term of your policy.

5. **PROFESSIONAL TRAINING**

Name of school, hospital, etc.	FROM Mo./ Day/Yr.	TO Mo./Day/Yr.	Type of training	Date of completion

6. **APPLICANT IS A MEMBER IN GOOD STANDING OF THE FOLLOWING PROFESSIONAL ORGANIZATIONS**

Name of organizations

7. **INSURANCE HISTORY**

List professional liability insurance history for the past ten (10) years.

Insurance Carrier	Effective Date	Expiration Date	Type of Coverage: Claims-Made or Occurrence	Limits of Coverage	Policy Number

8. **PROFESSIONAL ACTIVITIES**

Has any insurance company ever cancelled, declined to offer or declined to renew your professional liability insurance coverage? ☐ Yes ☐ No

If "Yes", ____
Name of insurance carrier/date (MM/YY)

Explain: ____

9. **Have you ever been placed on probation in any state or had your professional license or narcotics license revoked, suspended, restricted or voluntarily surrendered in any state?** ☐ Yes ☐ No

If "Yes", ____
Name of insurance carrier/date (MM/YY)

Explain: ____

10. **Are there any investigative or disciplinary actions by any governmental agency currently pending against you in any state?** ☐ Yes ☐ No

If "Yes", ____
Name of insurance carrier/date (MM/YY)

Explain: ____

11. **Are there any Health Care Facility or provider / managed care organization / professional association disciplinary proceedings pending against you?** ☐ Yes ☐ No

If "Yes", ____
Name of insurance carrier/date (MM/YY)

Explain: ____

12. **Have you ever had a malpractice claim or suit (closed or pending) made against you?** ☐ Yes ☐ No

If "Yes", complete a claim/lawsuit information page for each (page 12).

13. **Are you aware of any event(s) or incident(s) that may or will result in a claim against you?**

☐ Yes ☐ No

If "Yes," provide details of each and specify which you have reported to your current professional liability insurer:

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PRACTICE AND UNDERWRITING INFORMATION:

Indicate any procedures or therapies you perform in your practice. Provide additional information as requested and ***answer all questions***. ***If you do not perform a procedure check*:** ☐ **No**

	Yes	No
Acupuncture	☐	☐
Alternative medicine	☐	☐
Describe ______		
Anesthesia	☐	☐
If yes, specify where administered ______		
Botox, Restylane, Juvederm, other (specify) ______	☐	☐
Facial peels	☐	☐
Laser therapy	☐	☐
Laser type(s): ______		
Hair removal	☐	☐
Skin	☐	☐
Other ______		
Obstetrical/Gynecological Care	☐	☐
Limited to gynecological care	☐	☐
Direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital	☐	☐
Prenatal	☐	☐
Deliveries	☐	☐
Home deliveries	☐	☐
Birthing Center	☐	☐
VBACs	☐	☐
Surgery	☐	☐
Specify type(s)/where you assist: ______		
In non-hospital setting (specify where, type of surgery, and percentage of cases you assist ______		
Telemedicine	☐	☐
If yes, specify location of telemedicine patient population ______		
Weight control therapy	☐	☐
Medications prescribed ______	☐	☐

SUPPLEMENTAL APPLICATIONS

CERTIFICATION REQUIRED FOR MIDWIVES & NURSE MIDWIVES

The primary employer / collaborating physician must submit a letter describing the exact duties and collaboration involved with the Applicant. This letter must be on the letterhead stationery of the primary employer and signed by the collaborating physician. After review of this information and review of the Applicant, HIC will advise the Applicant of acceptability for insurance with the Company.

Coverage is provided only for your professional services while acting within the scope of your duties for your employer(s). Should insurance coverage be issued, it is an absolute condition of the insurance policy that HIC is the insurer of your employer(s), and that such insurance remain in full force and effect for the full term of your policy.

Acknowledgement of Supervision Requirements by Supervising Physician:

The following certificate must be signed by the Applicant's employer / supervising physician before insurance can be placed for a certified midwife or certified nurse midwife Applicant:

1. No more than a total of two (2) certified midwives or certified nurse midwives will be employed by one (1) physician;
2. The supervising physician and the certified midwife or certified nurse midwives must be in an employment relationship and maintain documentation of their relationship that is readily available upon request; and
3. Supervision shall be continuous; however, it shall not require the physical presence of the supervising physician at the time(s) and place(s) outlined in the attached letter.
4. Insurance coverage is provided on an "Occurrence" form

I understand that insurance, if issued to the Applicant, will be in reliance on these requirements.

____ ________________
Signature of Employer/Supervising Physician Date:

____ ________________
Full Name (please print): License #

CERTIFICATION REQUIRED FOR CERTIFIED REGISTERED NURSE ANESTHETISTS

The primary employer / collaborating physician must submit a letter describing the exact duties and collaboration involved with the Applicant. This letter must be on the letterhead stationery of the primary employer and signed by the collaborating physician. After review of this information and review of the Applicant, HIC will advise the Applicant of acceptability for insurance with the Company.

Coverage is provided only for your professional services while acting within the scope of your duties for your employer(s). Should insurance coverage be issued, it is an absolute condition of the insurance policy that HIC is the insurer of your employer(s), and that such insurance remain in full force and effect for the full term of your policy.

Acknowledgement of Supervision Requirements by Supervising Physician:

I hereby certify that I am the supervising physician of the Applicant and that the administration of anesthesia by the Applicant will be supervised as follows:

1. No more than three (3) Certified Registered Nurse Anesthetists will be employed by any one (1) HIC insured Anesthesiologist.
2. Each patient will be seen by an MD or DO Anesthesiologist before anesthesia is administered.
3. The Certified Registered Nurse Anesthetist will act only under the supervision of a HIC insured MD or DO Anesthesiologist and will not work independently. Such supervision will require physical availability of the MD or DO Anesthesiologist for immediate diagnosis and treatment of exceptional situations.
4. When anesthesia is administered by a Certified Registered Nurse Anesthetists, the hospital/medical chart will clearly reflect this fact.
5. Except in unusual situations, a single Anesthesiologist shall not simultaneously supervise more than three (3) Certified Registered Nurse Anesthetists. The supervising physician shall not be personally engaged in administering another anesthetic at the time he / she is providing such management.

I understand the insurance, if issued to the Applicant, will be in reliance on these requirements.

____ __________________
Signature of Employer/Supervising Physician Date:

____ __________________
Full Name (please print): License #

CERTIFICATION REQUIRED FOR NURSE PRACTITIONERS

Primary collaborating physician: ____

Additional collaborating physician: ____

Note: A HIC insured physician will not collaborate with more than four (4) Nurse Practitioners who are not located on the same physical premises

Coverage is provided only for your professional services while acting within the scope of your duties for your employer(s). Should insurance coverage be issued, it is an absolute condition of the insurance policy that HIC is the insurer of your employer(s), and that such insurance remain in full force and effect for the full term of your policy.

Acknowledgement of Collaborative Requirement for Nurse Practitioners: (please review and sign applicable practice **Guideline**)

Guideline "A"

1. **I do not have** more than 3600 hours of experience practicing as a licensed or certified nurse practitioner pursuant to the laws of New York or another state or practicing as an NP while employed by the US Veteran's administration, the US armed forces or the US public health service.
2. I perform medical services in accordance with written practice protocols and a written practice agreement with a collaborating physician (provide name): ______________________________ in the specialty area of practice: _________________________.
3. I maintain a copy of the written practice agreement and written practice protocols in accordance with New York State Education Department protocols.

I understand that insurance, if issued to the Applicant, will be in reliance on these requirements.

_______________________________________ _______________

Signature of Applicant Date:

Guideline "B"

1. I hereby certify that **I have** more than 3600 hours of experience practicing as a licensed or certified nurse practitioner pursuant to the laws of New York or another state or practicing as an NP while employed by the US Veteran's administration, the US armed forces or the US public health service.
2. I have a collaborative relationship with one or more New York State licensed and registered physicians who are qualified to collaborate in the specialty area of practice: ____________________.
3. I maintain a copy of the "Collaborative Relationships Attestation Form" in accordance with New York State Education Department protocols.

I understand that insurance, if issued to the will be in reliance on these requirements.

_______________________________________ _______________

Signature of Applicant Date:

_______________________________________ _______________

Signature of Employer/Supervising Physician Date:

CERTIFICATION REQUIRED FOR REGISTERED PHYSICIAN ASSISTANTS & SPECIALIST ASSISTANTS

The primary employer / collaborating physician must submit a letter describing the exact duties and collaboration involved with the Applicant. This letter must be on the letterhead stationery of the primary employer and signed by the collaborating physician. After review of this information and review of the Applicant, HIC will advise the Applicant of acceptability for insurance with the Company.

Coverage is provided only for your professional services while acting within the scope of your duties for your employer(s). Should insurance coverage be issued, it is an absolute condition of the insurance policy that HIC is the insurer of your employer(s), and that such insurance remain in full force and effect for the full term of your policy.

Acknowledgement of Supervision Requirements by Supervising Physician:

I hereby certify that I am the supervising physician / employer of the Applicant and that the administration of professional services by the Applicant will be supervised as follows:

1. No more than a total of four (4) Registered Physician Assistants will be employed by any one (1) HIC insured physician.
2. A Registered Physician Assistant may perform medical services when such acts and duties assigned to him / her are within the scope of practice of the supervising physician.
3. Supervision shall be continuous; however, it shall not require the physical presence of the supervising physician at the time(s) and place(s) outlined in the attached letter.

I understand that insurance, if issued to the Applicant, will be in reliance on these requirements.

____ ____________________

Signature of Employer/Supervising Physician Date:

____ ____________________

Full Name (please print): License #

Claim/Lawsuit Information – Answer all questions

Patient Name ____

Last First MI

Age ______________ Sex ☐ Male ☐ Female

Your relationship to patient

____

____

Nature of allegation in the claim or suit ____

Date of Incident ____

Report Date ____

Insurance Carrier ____

Name of other provider(s) and hospital(s), if any, involved in the claim or suit: ______________________

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Disposition of the claim

- ☐ Abandoned (no activity over 3 years)
- ☐ Won by defense
- ☐ Judgment or verdict vs. co-defendant(s) only
- ☐ Settled or ☐ won by claimant If so, how much was paid on your behalf? ________________
- ☐ Open (current status) ____

Location of Incident ____

Narrative description of the medical facts: (must include, but not be limited to the type of treatment and/or surgery and your involvement)

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The above information is complete and true to the best of my knowledge and belief.

____

Signature of Applicant

THE APPLICANT'S SIGNATURE IS REQUIRED FOLLOWING THE RELEASE OF INFORMATION AND INSURANCE DEPARTMENT REGULATION STATEMENTS

Release of Information

I hereby authorize HIC to obtain full information from any insurance company or from any person, health care facility, organization or governmental agency with respect to me or my practice or professional services, including but not limited to, any claim, suit or incident pertaining to professional acts or omissions asserted against me. I recognize that I may be required to furnish, as part of my application, a copy of my National Practitioner Data Bank report. I expressly release and discharge from liability any insurance company or persons, organizations or agencies, including but not limited to HIC, for providing or receiving such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

I appoint HIC (and/or such attorneys or representatives as it may appoint) to act in my behalf as attorney in fact in exercising any or all of my rights arising under or in relation to the policies of insurance, which are, have been, or will be in force for my benefit, including but not limited to the following: notification of claims; presentation of information and documentation; demand, receipt and remittance of payments and any other monies representing the liabilities of insurers under policies covering me, making of financial arrangements to facilitate the payment of claims and any other actions that HIC may deem necessary or useful. This appointment shall apply in respect of all insurance policies arranged for me by HIC, whether they be past, present or future.

I hereby attest that the statements made in this application are true, complete and accurate and may be relied upon by HIC for the purpose of issuing coverage.

New York State Insurance Department Regulation #95 declares that:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Signature: ______________________ Date: ____________

Full Name (please print): ______________________ License # ____________