

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: _____

<u>Title: Professional Designation</u>	<u>License Number</u>
<input type="checkbox"/> Certified Midwife (CM)	_____
<input type="checkbox"/> Certified Nurse Midwife (CNM)	_____
<input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)	_____
<input type="checkbox"/> Nurse Practitioner (NP)	_____
<input type="checkbox"/> Registered Physician Assistant (PA)	_____
<input type="checkbox"/> 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:

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	<input type="checkbox"/>	<input type="checkbox"/>
Alternative medicine	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify where administered _____		
Botox, Restylane, Juvederm, other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

Facial peels	<input type="checkbox"/>	<input type="checkbox"/>
Laser therapy	<input type="checkbox"/>	<input type="checkbox"/>
Laser type(s): _____		
Hair removal	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Obstetrical/Gynecological Care	<input type="checkbox"/>	<input type="checkbox"/>
Limited to gynecological care	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal	<input type="checkbox"/>	<input type="checkbox"/>
Deliveries	<input type="checkbox"/>	<input type="checkbox"/>
Home deliveries	<input type="checkbox"/>	<input type="checkbox"/>
Birthing Center	<input type="checkbox"/>	<input type="checkbox"/>
VBACs	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Specify type(s)/where you assist: _____		
In non-hospital setting (specify where, type of surgery, and percentage of cases you assist		

Telemedicine	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify location of telemedicine patient population _____		
Weight control therapy	<input type="checkbox"/>	<input type="checkbox"/>

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.

<p>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.</p>

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: _____

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)

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.

<hr/> Signature:	<hr/> Date:
<hr/> Full Name (please print):	<hr/> License #