

**AMERICAN PHYSICIANS ASSURANCE CORPORATION**

Headquarters: 1301 N. Hagadorn Road, P.O. Box 1471, East Lansing, MI 48826-1471, 1-800-748-0465  
 New Mexico Office: 7770 Jefferson St., NE, Suite 410, Albuquerque, NM 87109-4368, 1-800-880-9485

**Application for Healthcare Providers**

**American Physicians Policy No.:** \_\_\_\_\_  
 (Leave blank if you do not currently have your professional liability insurance with American Physicians.)

**FOR AMERICAN PHYSICIANS USE ONLY**

**CLIENT NO:** \_\_\_\_\_ **APP ID:** \_\_\_\_\_  
**ACN NO:** \_\_\_\_\_

**Agency Name:** \_\_\_\_\_ **Agency Code:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Agency Phone:** ( ) \_\_\_\_\_ **Agent or Representative:** \_\_\_\_\_

Please type or legibly print your responses in full. Supplement this application with responses to questions requiring more room than contained in this form and submit copies of the documents requested on the last page of this application.

1. Name (First, Middle, Last):	2. Title:
3. Social Security Number:	4. Date of Birth:
6a. E-mail Address:	5. <input type="checkbox"/> Male <input type="checkbox"/> Female
6b. Website Address:	

**7a. Mailing Address:**

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Office Fax: ( )
Contact (If other than self):		Telephone: ( )

**7b. Principal Office Address:** (If different than mailing address)

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Office Fax: ( )
Contact (If other than self):		Telephone: ( )
<b>Kentucky residents only:</b> Is this address within city limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**7c. Residence Address:** (If different than mailing address)

Street:		
City/State/Zip:		
County:	Residence Telephone: ( )	Residence Fax: ( )

**7d. Additional Offices:** (Attach a separate sheet for additional office locations.)

Street:		
City/State/Zip:		
County:	Office Telephone: ( )	Office Fax: ( )

8. What is the complete Medical Corporation / Professional Organization Name and Federal ID Number of the physician/group entity that is employing you? Please **attach a copy of the Articles of Incorporation**.

Name: \_\_\_\_\_ Federal ID Number: \_\_\_\_\_

9. Is the above physician/group entity a:  Solo practitioner (Incorporated)  Solo Practitioner (**NOT** Incorporated)  
 Partnership  PC  SC  
 Other – Please describe: \_\_\_\_\_

10. Check your specific professional occupation:

<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Podiatrist – Including Surgery	<input type="checkbox"/> Surgical Assistant
<input type="checkbox"/> Nurse Anesthetist	<input type="checkbox"/> Perfusionist	<input type="checkbox"/> Podiatrist – No Surgery	
<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Psychologist	
<input type="checkbox"/> Other – Please specify professional occupation: _____			

11. State license/certification number (**Please attach a copy**):

12. Type of coverage requested: **COVERAGE MUST BE THE SAME AS THE EMPLOYING PHYSICIAN/GROUP ENTITY. TO AVOID ANY GAPS IN THIS IMPORTANT INSURANCE COVERAGE, PLEASE CONSULT YOUR AMERICAN PHYSICIANS AGENT OR OTHER REPRESENTATIVE ABOUT THE DIFFERENCES IN THESE INSURANCE FORMS.**

<input type="checkbox"/> Claims-made ( <b>Not available in all states</b> ) Covers incidents that take place and are reported during the policy period, which begins with the retroactive date.	<input type="checkbox"/> Occurrence ( <b>Not available in all states</b> ) Covers incidents that take place during the policy period regardless of when reported as a claim.
<input type="checkbox"/> TailGard® ( <b>Available in Michigan only</b> ) Claims-made coverage with a pre-paid reporting period extension.	

13. Requested limits of insurance: **NOT ALL OF THE LIMITS LISTED BELOW ARE AVAILABLE IN ALL STATES. PLEASE CONSULT YOUR AMERICAN PHYSICIANS AGENT OR OTHER REPRESENTATIVE FOR DETAILS.**

- |  |  |
|--|--|
| <input type="checkbox"/> \$100,000 per incident/\$300,000 policy aggregate | <input type="checkbox"/> \$500,000 per incident/\$1,000,000 policy aggregate       |
| <input type="checkbox"/> \$200,000 per incident/\$600,000 policy aggregate | <input type="checkbox"/> \$500,000 per incident/\$1,500,000 policy aggregate       |
| <input type="checkbox"/> \$250,000 per incident/\$750,000 policy aggregate | <input type="checkbox"/> \$1,000,000 per incident/\$3,000,000 policy aggregate     |
| <input type="checkbox"/> \$300,000 per incident/\$900,000 policy aggregate | <input type="checkbox"/> Other: \$ _____ per incident<br>\$ _____ policy aggregate |

14. Requested effective date (12:01 a.m.): \_\_\_\_\_

Requested retroactive date (12:01 a.m.): \_\_\_\_\_

A “retroactive date” is applicable for “Claims-made” coverage only. Claims-made coverage is limited to claims which are first made while the insurance is in force and which arise out of professional incidents that first occur on or after the retroactive date.

15. Average number of patients per week: \_\_\_\_\_

16. Average number of hours practiced per week:  
(Including on call, charting, teaching, phone consultations, etc.) \_\_\_\_\_

17. If you are an owner, operator, officer, partner, administrator, or have a similar capacity for any other healthcare or related services organization, please identify and explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. List all states where you are licensed/certified (attach a separate sheet of paper if additional space is needed):

State	License/Certification Number (If applicable)	Average number of hours per week per state

19. List all hospitals and surgicenters where you have privileges during the period of time you wish to be covered.

Name	City	County	State	Percentage of Practice

**In responding to questions 20a through 27, please explain any “yes” response on supplementary pages and attach to this application.**

20a. Has any licensing authority ever refused you a license or certification to practice medicine?  Yes  No

20b. Has any licensing authority ever restricted, suspended or revoked your license to practice medicine?  Yes  No

20c. Have you ever voluntarily surrendered a license to practice medicine?  Yes  No

20d. Has any licensing authority ever placed you on probation or restricted your practice?  Yes  No

20e. To your knowledge, is your license to practice currently under investigation?  Yes  No

21. Has any hospital or healthcare institution ever denied, restricted, reduced, or suspended your privileges or invoked probation?  Yes  No

22. Do you prescribe drugs?  Yes  No

23. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise?  Yes  No

24. Are you currently being or have you ever been treated for, or suffered from, alcoholism, chemical dependency, a mental disorder, or mental illness?  Yes  No

25. Do you perform surgical procedures?  Yes  No

If yes, please indicate where:  Office  Clinic  Surgicenter  Hospital

26. Have you signed any contractual agreements where you agreed to indemnify (hold harmless) others?  Yes  No

If yes, please submit a copy of the contract.

27. Do you perform or assist in general anesthesia procedures where patients are rendered unconscious?  Yes  No

a. \_\_\_\_\_% of procedures completed in hospital only

b. \_\_\_\_\_% of procedures completed in office

c. \_\_\_\_\_% completed in other facilities, including ambulatory surgery

28. List all medical societies, medical associations, or other related professional societies to which you belong.


29. Check the highest level of education you have completed relating to practice in your field:
- None Required       Baccalaureate Degree       Post-Doctorate Degree  
 Diploma       Masters Degree       Other: \_\_\_\_\_  
 Associates Degree       Doctorate Degree      \_\_\_\_\_

School of Graduation: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

30. Do you intend to carry, or do you currently carry, any other medical professional liability insurance from any other insurer while this insurance is in effect?  Yes  No

**If yes, describe and submit proof of coverage:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

31. Beginning with your most recent or current insurer, please list **ALL** current and prior medical professional liability insurers. Please explain any gaps in the continuity of your professional liability coverage.

Name of Insurer	Coverage Type (Claims-made or Occurrence)	Policy Number	Policy Period

32. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you or any professional association, corporation, or partnership to which you currently belong or have belonged to in the past?  Yes  No

If yes, has such incident(s) been reported to a prior professional liability insurer and has that insurer acknowledged coverage for the incident(s)?  Yes  No

**Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application. The name, age, and sex of the patient, date of incident, details of what happened and why, insurer of the incident and disposition including claims amount or current status must be included.**

33. Do you have knowledge of any claims, potential claims, or suits in which you or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rendering of, or failure to render, professional services which may give rise to a claim?  Yes  No

If yes, has this incident (these incidents) been reported to a prior insurer?  Yes  No

**Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application.**

**FRAUD WARNING**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION OF A MATERIAL NATURE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO IMPRISONMENT, FINES AND DENIAL OF INSURANCE.**

**APPLICANT’S REPRESENTATIONS, WARRANTIES AND AUTHORIZATION**

I understand that no coverage will be bound until after American Physicians Assurance Corporation has reviewed this completed application and formally bound the requested coverage. Acceptance of payment is not an expression of American Physicians Assurance Corporation’s intent to provide coverage. If coverage is declined by American Physicians Assurance Corporation, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage or retroactive coverage on my professional liability policy, such coverage will apply only to liability arising out of an occurrence which happened prior to the effective date of the policy and subsequent to the retroactive date of the policy for which I am applying. It is agreed that no insurance will be provided for:

1. any claim which has been reported to another insurance carrier prior to the effective date;
2. any claim known to the insured at the effective date which has not been reported to a prior carrier;
3. any claim that may arise out of an incident which has been reported to another insurance carrier prior to the effective date;
4. any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.

I specifically represent and warrant to the insurer that the information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter’s judgment when considering this application or that might be material to the acceptance of the risks described to the underwriter in this application. I understand and acknowledge that this completed application shall be considered an integral part of any insurance policy issued to me by the insurer. I further agree that any false or misleading statement in this application shall be grounds for the insurer to cancel and void coverage at its sole and absolute discretion.

I authorize the release of any underwriting and/or claim information (and release from any and all liability for the provision of information) from all prior and current insurers, all professional societies or associations, any state licensing authority, or at any hospitals or healthcare institutions to American Physicians Assurance Corporation and its subsidiaries or agents.

I agree to cooperate with the Risk Management Department of American Physicians Assurance Corporation, and its subsidiaries or agents, including the performance of practice risk assessments when deemed appropriate by American Physicians Assurance Corporation and to support their efforts to enhance quality of patient care.

Signature	Title	Date
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**ASSIGNMENT OF RIGHT TO CANCEL COVERAGE**

I assign to my employer, \_\_\_\_\_, both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to: American Physicians Assurance Corporation

Initial Here:

**Please attach:**

- Copy of current/most relevant state license/certification
- Copy of current declarations page
- Supplemental Claim Information Form for each claim, regardless of outcome
- Current loss runs from previous carriers