First Professionals Insurance Company

Application

FOR PROFESSIONAL ANCILLARY EMPLOYEES

Medical Professional Liability Insurance Policy
Claims-Made
Non-Assessable

Ancillary Employee Application

Application for Professional Liability Insurance
Employed by Current FPIC Policyholders

RETURN APPLICATION TO:
Your Insurance Agent or
First Professionals Insurance Company
1000 Riverside Avenue, Suite 800
Jacksonville, FL 32204
Mailing Address: P. O. Box 44033
Jacksonville, FL 32231-4033
(904) 354-5910 • (800) 741-3742
Fax: (904) 358-6728
www.firstprofessionals.com

Please type or print

All statements below must be completed and all questions answered completely.

PLEASE DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER OR POLICY FROM THIS COMPANY HAS BEEN RECEIVED AND IS IN EFFECT.

PERSONAL INFORMATION

1. Name____Social Security No.____________________

a. Employer's Name ______________________________________Policy Number ______________

2. a. Employer's Mailing Address____
(Street/P. O. Box) (City/State/Zip)

b. Your Home Mailing Address____
(Street/P. O. Box) (City/State/Zip)

3. Date of Birth_________________Place of Birth____

4. ____
Phone Number Fax Number E-Mail Address

5. a. For the following occupations, complete this application ONLY IF REQUESTING COVERAGE SEPARATE FROM EMPLOYER. Shared coverage is provided automatically and does not require an application:

- ☐ Certified Nursing Assistant
- ☐ Dental Hygienist
- ☐ Dietitian/Nutritionist
- ☐ LPN, LVN, Aide, and First Year RN
- ☐ Med. Laboratory Technician
- ☐ Mental Health Counselor
- ☐ Psychologist
- ☐ Respiratory Therapist
- ☐ O.R. Technician (Hospital)
- ☐ Optician
- ☐ Paramedic
- ☐ Perfusionist-Heart/Lung
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Psychotherapist
- ☐ Other * __________________

RN:
- ☐ *Critical Care*
- ☐ *ER*
- ☐ *First Assist*
- ☐ *General Duty*
- ☐ *OB*
- ☐ *Scrub*

- ☐ Surgeon Assistant

*Describe General Duties____

b. For the following occupations, an application must be completed in all cases. Please indicate whether the requested coverage is to be shared with the employer or separate from the employer.

☐ Nurse Anesthetist ☐ Nurse Practitioner ☐ Physician Assistant ☐ Nurse Midwife

☐ Separate limits from employer ☐ Shared limits with employer

6. I request an Effective Date of 12:01 a.m. on___________________ Retroactive Date ________________

I request policy limits of : (**select one**)

☐ $250,000/$750,000 ☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

7. List the states where you practice and license numbers, if applicable:

State	Percentage of Practice in State	License Number	License Status Active?
			☐ YES ☐ NO

8. Have you ever:

a. Had your license or certification suspended, denied, revoked, or restricted in any state? ☐ YES ☐ NO
b. Had your insurance for medical malpractice refused, cancelled, suspended, non-renewed, declined, or accepted on special terms? ☐ YES ☐ NO
c. Had any fee or professional relations complaints registered against you with your association(s), hospital(s), state licensing authority, or certifying body? ☐ YES ☐ NO
d. Been denied staff or hospital privileges or had privileges suspended, terminated or revoked? ☐ YES ☐ NO
e. Been treated or hospitalized for any mental or emotional disorders? ☐ YES ☐ NO
f. Incurred or become aware of having an illness or physical disability which impairs or could impair your ability to perform your duties? ☐ YES ☐ NO
g. Been charged with or convicted of a felony or misdemeanor other than minor traffic violations? ☐ YES ☐ NO
h. Been treated or hospitalized for use of any of the following:
   i. alcohol ☐ YES ☐ NO
   ii. narcotics ☐ YES ☐ NO
   iii. central nervous system stimulants or depressants ☐ YES ☐ NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET OF PAPER.

9. **a.** Do you treat patients at a nursing home, assisted living facility, jail or correctional facility? ☐ YES ☐ NO
If yes, please explain:______________________________

____

b. Do you want this FPIC coverage to protect you for an exposure outside the scope of your employment by the FPIC insured?

☐ YES ☐ NO

If yes, please explain:______________________________

____

c. Do you perform any cosmetic procedures, such as, but not limited to injections of neurotoxins or dermal fillers?

☐ YES ☐ NO

If yes, please advise which procedures you perform and attach proof of training: ______________________________

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PRIOR PROFESSIONAL LIABILITY INSURANCE

10. Name of Insurance Company	Policy Number	Policy Period	Type of Coverage Claims-Made or Occurrence	Retroactive Date

(Attach copy of current coverage summary sheet if you are requesting prior acts coverage.)

CLAIMS INFORMATION

11. Have you ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten (10) years, including any expression of an intent (i.e. closed records requests, incident reports and Notices of Intent, even if suit was never filed), or are you presently involved in malpractice litigation? ☐ YES ☐ NO
If yes, how many? ___________

12. Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?

a. A request for records from a patient and/or attorney related to an adverse outcome? ☐ YES ☐ NO

b. A letter or communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient? ☐ YES ☐ NO

c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? ☐ YES ☐ NO

d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories? ☐ YES ☐ NO

i. Cardiac arrest ☐ YES ☐ NO

ii. Postoperative coma ☐ YES ☐ NO

iii. Postoperative neurological deficits ☐ YES ☐ NO

iv. Unexpected death within 48 hours postoperatively ☐ YES ☐ NO

13. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? ☐ YES ☐ NO

14. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits **(EVEN IF YOU BELIEVE THE OUTSTANDING CLAIM OR SUIT WOULD BE WITHOUT MERIT)** that have not been reported to your current OR prior professional liability carrier? If yes, please explain ______________________________ ☐ YES ☐ NO

15. Has any other party (e.g. current or prior employer, physician, etc.) been the subject of a claim due to your actions? ☐ YES ☐ NO

(Complete claims information form on each claim or suit.)

CLAIMS INFORMATION FORM

Patient's Name______________________________ Patient's Age ______________________

Incident Date______________________ Date Reported to Carrier ______________________

Insurance Carrier______________________ Policy Number______________________

Name of Attorney Representing You__________________ Name of Supervising Physician__________________

Treatment Rendered____

Allegations ____

What is the present condition of this patient? ______________________________

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, pertaining to this claim? ☐ YES ☐ NO

Present status of claim (check applicable answers):

- ☐ Suit threatened, no action taken
- ☐ Dropped by claimant
- ☐ Summary judgment in your favor
- ☐ Court trial in your favor
- ☐ Notice of Intent filed
- ☐ Suit filed: Reserve Amount $_______________
- ☐ Out of court settlement:
  Date paid _____________ Amount paid $_______________
- ☐ Court settlement:
  Date paid _____________ Amount paid $_______________

The above is a true and correct statement. By signing this application, I hereby authorize my prior carrier to release any claim information requested by FPIC.

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with First Professionals Insurance Company (FPIC). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences or circumstances related to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of FPIC in considering this application for professional liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by FPIC and I am notified of said acceptance. Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by FPIC. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Resource Network, individuals and FPIC. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source. I understand that, if I am insured by FPIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with FPIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FPIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FPIC.

FRAUD STATEMENT
Section 817.234(1)(b), Florida Statutes (if applicable)

The statute requires the statement to contain in substance the following language: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

SIGNATURE OF APPLICANT

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the application does not bind the applicant or FPIC to complete the insurance.

(A copy of this authorization shall be considered as effective and as valid as the original.)

Signature of Applicant ______________________________ Date____________________

If you have a resume or a CV, please attach a copy to this application.