Allied Health Professional Liability Renewal Application

ProAssurance Casualty Company • PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 608.828.1100

Important: Please review, complete, and return this renewal application with a copy of your updated curriculum vitae and a copy of your current business letterhead. Please make any necessary changes to the pre-filled information below. Your prompt, accurate reply assists your policy's renewal. Thank you.

1. Personal Information

Name: _____

Social Security Number: _____ Date of Birth: _____ / _____ / _____

Place of Birth: _____

Home Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

2. Office Information

Current Employer: _____

Principal Office Street Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Professional office located within the city limits of: _____

Office Phone: _____ Office Fax: _____ Email: _____

UPIN: _____ Contact Name and Phone: _____

Note: Please attach a copy of your current business letterhead and curriculum vitae. ☐ Yes, I have done so.

Current Certificate of Insurance Holders: Please cross out any Certificate holders you no longer need and use additional lines to add other Certificate holders to whom we should mail a Certificate.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Note: If you answer yes to any of the following questions, please give us details in the space provided at the end of the application, under the Additional Comments section on page 4, or attach a separate sheet.

3. Practice Information

A. Has your place of employment changed? Yes ☐ No ☐
If yes, please specify. _____

B. Has your profession or title changed? Yes ☐ No ☐
i. If yes, please specify. _____
ii. Briefly describe your duties or areas or practice. _____

C. Have you taken any additional training? Yes ☐ No ☐
If yes, please specify. _____

D. Are you a member of any professional organization? Yes ☐ No ☐
If yes, please give details. _____

E. Do you moonlight (work outside control of employer)? Yes ☐ No ☐
If yes, where? _____

F. Will you be scheduled to work at a separate location from your supervising physician? Yes ☐ No ☐
If yes, please give details on a separate sheet.

G. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? Yes ☐ No ☐

H. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes ☐ No ☐

I. Do you order or perform diagnostic tests? Yes ☐ No ☐

J. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referrals and consultations when needed? Yes ☐ No ☐

K. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes ☐ No ☐

L. Do you perform a physical examination? Yes ☐ No ☐
If yes, briefly describe techniques and instruments used: _____

M. Do you conduct informed consent discussions? Yes ☐ No ☐

N. Do you perform acupuncture or other types of alternative medicine? Yes ☐ No ☐
If yes, please attach evidence of training.

O. Describe any other procedures, treatments, or duties you perform.

P. Describe your procedures for notifying your supervising physician of situations beyond the scope of your training or practice.

4. Claims Information

A. Have any new claims been filed with your previous insurance carrier(s)? Yes ☐ No ☐

If yes, please describe under additional comments.

B. Have any new payments been made or has there been a change in the status of an existing claim with your previous insurance carrier(s)? Yes ☐ No ☐

If yes, please provide details. _____

_____

5. Personal History

If you answer yes, to any of the questions below, provide complete details at the end of the application or attach a separate sheet.

A. Have you ever been convicted of a criminal offense? Yes ☐ No ☐

B. Have you ever been treated (or recommended for treatment) for alcoholism, sexual, or drug addiction? Yes ☐ No ☐

C. Have you ever undergone (or been recommended to undergo) psychiatric treatment? Yes ☐ No ☐

D. Have you ever had a complaint filed against you with any hospital or regulatory board? Yes ☐ No ☐

E. Have you ever had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? Yes ☐ No ☐

I have noted below and agree to notify the Company going forward of any the following events within thirty (30) days of its occurrence: (Please note any circumstances below under Additional Comments.)

A. A change in my specialty or medical procedures performed;

B. A change in my practice location, my provision of services to out-of-state patients, or telemedicine services;

C. Complaint, grievance, investigation, restriction, suspension, or surrender of any state medical license, DEA license, or hospital privileges;

D. Investigation of my Medicare/Medicaid billing procedures;

E. Any physical or mental condition or illness, including treatment for alcohol or substance abuse or any accusation of sexual misconduct or inappropriate contact not previously disclosed to the Company in writing;

F. Conviction, plea, or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses;

G. A claim or suit for alleged malpractice has been made against me and reported to **another insurance carrier or hospital self-insured trust**, or if any claim or suit resulted in payment by me or on my behalf, since I became an insured of a ProAssurance company.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

Failure to notify the Company of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof:

Date: _____ **Signature of Insured Allied Health Professional**: _____

Additional Comments

Please attach additional sheets as necessary.