# NON-PHYSICIAN HEALTH CARE PROVIDER PROFESSIONAL LIABILITY INSURANCE APPLICATION


You are applying for coverage under *Conventus'* claims-made policy. If your application is accepted by *Conventus*, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to *Conventus* either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

**900 Route 9 North, Suite 503, Woodbridge, New Jersey 07095**

**Phone: (877) 444-0484** **Fax: (732) 791-9431**

**www.conventusnj.com**

CONVENTUS

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**Section I – General Information (All questions must be completed. If no or none, so state.)**

1. Name and address of applicant

_____
_____
_____
_____
_____

Contact person _____
Phone _____
Fax _____
E-Mail _____

2. Broker name and address

_____
_____
_____
_____
_____

Phone _____
Fax _____
E-mail _____

3. Birth Date _____

4. Social Security Number _____

5. List all locations where you work.

| Employer | Street | City | County | State | Zip | Specialty | # hrs per mo | Phone |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

6. Requested policy period from: _____ to: _____

7. Requested retroactive date _____

8. Limits of liability if separate policy is desired:

☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ Other _____

9. Do you practice as:

☐ Graduate Nurse
☐ Licensed Practical Nurse
☐ Nurse Anesthetist
☐ Nurse midwife – deliveries
☐ Nurse midwife – no deliveries
☐ Nurse Practitioner
Specialty_____
☐ Clinical Nurse Specialist
☐ Other (describe)_____

☐ Optician
☐ Optometrist
☐ Pharmacist
☐ Physical Therapist
☐ Physician's Assistant
(with surgical assisting?)
☐ Yes ☐ No
☐Psychiatric Nurse

☐ Registered Nurse
☐ Student nurse
☐ X-Ray Therapist
☐ First Nurse Surgical Assistant
☐ Dental Assistant/Hygienist
☐Licensed Counselor
☐Social Worker
☐ Psychologist

*Please attach a copy of all licenses and/or certifications.*

10. Type of practice (Check all that apply)

☐ Employed Provider ☐ Sole Proprietor/Unincorporated ☐Limited Liability Corporation
☐ Professional Association ☐ Independent Contractor ☐ Principal in a Professional Corporation
☐ Partnership ☐ Other (describe)_____

11. List all states in which you are or have ever been licensed or certified.

| State | License # | Certificate # | Current Yes/No |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please explain, in detail, any "Yes" answers**

12. Has your professional license ever been denied, suspended, revoked or Voluntarily surrendered or has probation been invoked? ☐ Yes ☐ No

13. Are you currently aware of any investigation being conducted which could impact your license? ☐ Yes ☐ No

14. School of graduation _____ Degree _____ Date _____

15. Provide detailed description of your principal activity while working.

16. Do you provide any service over the Internet or through a telemedicine program? ☐ Yes ☐ No

17. Percentage of practice by state.

| State | % of patients | % of hospital | % of office hours |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

18. Has your employment ever been terminated? ☐ Yes ☐ No

19. Are you currently being, or have you ever been, treated for alcoholism or substance abuse? ☐ Yes ☐ No

20. 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, your employees or any professional association, corporation or partnership to which you belong or have belonged? ❒ Yes ❒ No
If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage? ❒ Yes ❒ No

**Please provide completed details for each incident on the Supplemental Claims Information Form and attach to this application. The name 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.**

21. Do you have knowledge of any claims, potential claims, circumstances that could possibly result in claims, or suits in which you, your employees, 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 completed details for each incident on the Supplemental Claims Information Form and attach to this application. The name 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.**

22. Name of current professional liability insurance carrier. _____

Policy Number _____ Expiration Date _____

Type of Coverage: ☐ Occurrence ☐ Claims-Made

If Claims-Made, was tail coverage purchased? ☐ Yes ☐ No

23. Has any company ever cancelled, not renewed or refused coverage? ☐ Yes ☐ No

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24. Do you follow all state laws, federal laws and specific national association protocols? ☐ Yes ☐ No

If "No", please explain and attach a copy of the protocols followed:

**Section II – Signature**
**This section must be completed by all applicants.**

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind *Conventus* to complete the insurance, but it is agreed that this application shall be the basis of a contract should a policy be issued. I authorize the release and exchange of any underwriting or claims information between all prior carriers and *Conventus.*

Signature of Applicant _____ Date _____

I understand that *Conventus* reserves the right to reject any applicant that does not meet its underwriting standards.

**Notice to New Jersey Applicants:** 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 subjects such person to criminal and civil penalties.