CONVENTUS
MEDICAL PROFESSIONAL LIABILITY INSURANCE

Non-Physician Healthcare Provider Professional Liability Insurance Application

Section I – General Information. Please print legibly. If a question is not applicable, state "N/A."

First Name | Middle Name/Initial | Last Name | Former Name/Alias, if applicable

Professional Designation(s) e.g., NP, PA, CRNA, etc. | Suffix | Date of Birth MM/DD/YYYY | Gender

License # | State | NPI #

Practice Name/Employer

Practice Address (include city, state and zip)

Office Phone | Office Fax:

Email Address

Section II – Coverage Information

Please list your prior professional liability insurance, if any.

Insurance Carrier | Coverage Type | Policy Number | Effective Date | Limits

Requested Effective Date: _____ MM/DD/YYYY Requested Retroactive Date: _____ MM/DD/YYYY

Professional Liability Limits Desired (check one)

☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ Other_____

Policy type requested (check one) ☐ Claims-Made Policy ☐ Modified Claims-Made Policy

Section III – Practice Information

Formal Written Agreements – NP, APN, PA, or CNMW only
Note: If you indicated Yes, please provide a copy of the Agreement. If "No", please explain in the Remarks section

Credential/Designation	Formal Written Agreement	Yes	No	N/A
Nurse Practitioners/Advanced Practice Nurses	Do you have a joint protocol with a collaborating licensed NJ physician?			
Physician Assistants	Do you have a signed delegation agreement with the supervising licensed NJ physician?			
Certified Nurse Midwife	Do you have a detailed formal consulting agreement with the licensed NJ physician?			

Scope of Practice
If yes, please you will (maybe) be requested to fill out an appropriate Supplemental Application

Yes	No	
		Prescribe controlled dangerous substances?
		– If yes, do you possess DEA certification and CDS registration?
		Do you provide Virtual Care or Telemedicine Services?
		Does your practice involve pain management or medicinal cannabis?
		Do you perform any Medspa services or procedures? (e.g., Neuro Modulators, Botox or Juvéderm injections , microneedling, Chemical Peels etc.) If yes, please specify services/procedures you are performing and the training you received.
		Do you perform IV infusion therapy? (e.g., Vitamin infusion therapy, etc.) If yes, please specify what you are doing and the training you received.

Practice Locations
List all locations where you currently work and/or anticipate working, include number of hours worked per week.

Employer/Facility Name	*Address*	*To be Covered by Conventus Policy? Yes/No*	*Hours Worked Per Week*

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

State	*License#*	*Certificate#*	*Current Yes/No*

Section IV –Profile Information

NOTE: If you answer Yes to any of the following questions, please provide detailed information in the **Remarks** section of this application.

Yes	No	
		Has your membership in any medical society or professional organization every been denied, suspended, revoked, voluntarily surrendered, or accepted on a restricted basis?
		Has your professional license, and if applicable, hospital privileges or reimbursement privileges, ever been revoked, voluntarily suspended, or subjected to probation/restrictions or are you aware of any circumstances that might lead to such?
		Are you aware of any investigation being conducted which could impact your license?
		Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act?
		Have you ever been accused of sexual misconduct of any kind?
		Has your employment ever been terminated or restricted?
		Have you ever incurred, become aware of having a condition that impairs your ability to practice medicine? (e.g., addiction to alcohol, narcotics or other controlled substances, mental illness etc.) In the event of such impairment, a statemen from you physician attesting to your fitness to practice must accompany this application
		Have you ever practiced without professional liability coverage?
		Has a professional liability insurance company ever declined, refused, canceled, surcharged or non-renewed your coverage?
		Has any claim or suit for alleged malpractice ever been brought against you or do you have knowledge of any potential claim that may be brought against you?

Remarks

Section V- Signature

I understand that no coverage will be bound until after *Conventus* Inter-Insurance Exchange has reviewed the completed application and expressed its intention to provide coverage.

I understand that, if granted prior acts coverage by *Conventus*, no insurance will be provided for any claim (or incident that the insured has reason to believe might result in a claim) known to the insured at the effective date that has, or has not, been reported to another insurance carrier prior to the effective date.

I declare that the information provided in this application is true, complete and accurate to the best of my knowledge and belief. 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 underwriter's risk.

I understand that the statements and answers will be relied upon by Conventus and are material in determining not only whether insurance coverage will be issued or renewed.

I authorize the release of any underwriting, credentialing and/or claim information from (and release from any and all liability for the provision of information) all prior and current insurers, all professional societies or associations, any state licensing authority, any hospitals, or any credentialing agency to *Conventus* and its subsidiaries, or agents, or Attorney-in-Fact.

I represent the information provided in this application (and attachments) is true. I understand (1) that this application and any previous applications are the basis of an will become part of the coverage contract with Conventus; (2) that the application information I provided is material to Conventus; (3) that Conventus is relying on this information in determining whether to issue a coverage contract and in establishing the premium to change; and (4) that Conventus may rescind or void the coverage if this application contains any misrepresentations or omissions.

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.

Signature of Applicant: _____ Date: _____

Conventus reserves the right to reject any application that does not meet its underwriting standards.

Page _____ of _____ SUPPLEMENTAL CLAIMS INFORMATION SHEET

Complete for all closed, pending, or potential claims(s).

Claimant's/plaintiff's name: _____

Date care rendered: _____ Date claim reported: _____

Status: ☐ Open ☐ Closed Date closed: _____

If closed, was any indemnity payment or award made? ☐ Yes ☐ No If Yes, amount: _____

If open, what is the amount of loss reserve or damages sought? _____

Name of insurance company defending you: _____

Are you the primary target of the complaint? ☐ Yes ☐ No If No, who is? _____

Description of claim (Include type of treatment, result of treatment, your involvement):

Claimant's/plaintiff's name: _____

Date care rendered: _____ Date claim reported: _____

Status: ☐ Open ☐ Closed Date closed: _____

If closed, was any indemnity payment or award made? ☐ Yes ☐ No If Yes, amount: _____

If open, what is the amount of loss reserve or damages sought? _____

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