



The Medical Assurance Company, Inc.  
 Castle Creek VI  
 5975 Castle Creek Parkway North Drive, Suite 300  
 Indianapolis, IN 46250  
 (317) 558-2500 / (800) 284-7424

MacLennan & Bain Insurance  
 214 Aberdeen Drive  
 Valparaiso IN 46385

## APPLICATION FOR LIMITED PROFESSIONAL LIABILITY COVERAGE INSURED PARAMEDICAL EMPLOYEE

Requested Effective Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Month Day Year

(Please Print or Type)

NAME \_\_\_\_\_ S.S. \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_  
Last First MI

HOME ADDRESS \_\_\_\_\_  
Street City State Zip

CURRENT EMPLOYER \_\_\_\_\_  
Name Telephone Number

BUSINESS ADDRESS \_\_\_\_\_  
Street City State Zip

TOTAL NUMBER OF HOURS WORKED PER WEEK \_\_\_\_\_

1. Profession:
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Physician's Assistant   | <input type="checkbox"/> Perfusionist     | <input type="checkbox"/> Certified Nurse Practitioner           |
| <input type="checkbox"/> Surgeon's Assistant     | <input type="checkbox"/> Optometrist      | <input type="checkbox"/> Certified Registered Nurse Anesthetist |
| <input type="checkbox"/> Psychologist            | <input type="checkbox"/> Cytotechnologist | <input type="checkbox"/> Emergency Medical Technician           |
| <input type="checkbox"/> Certified Nurse Midwife |   |   |

2. Is your employer insured by Medical Assurance?  Yes  No

3. Have you ever:
- |  |  |
|--|--|
| A. been convicted of a criminal offense?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. been treated for (or recommended for treatment) for alcoholism, sexual, or drug addiction?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. undergone psychiatric treatment?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. had a complaint filed against you with any hospital or regulatory board?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| E. had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E.  
 is "Yes," please provide complete details  
 on a separate sheet of paper.**

4. Do you moonlight (work outside control of employer)?  Yes  No  
 If "Yes," where and total number of hours worked per week?

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5. Do you hold the certification or licensure required in your state to practice your profession?  Yes  No  
 If "Yes," where did you receive your training?

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6. Are you a member of any professional organization? If "Yes," please give details.  Yes  No

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7. Have any judgments ever been rendered against you or any out-of-court settlements in excess of \$500 been made in your behalf from an incident alleging professional errors or omissions?  Yes  No  
 If "Yes," give details on a separate sheet. If available, please enclose copy of complaint.

8. Has any action been filed against you or have you been notified that any action, regardless of dollar amount will be filed against you alleging professional errors or omissions? If "yes," give details on a separate sheet. If available, please enclose copy of complaint.  Yes  No

9. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, or refused to renew, your insurance or offered Professional Liability Insurance only on special terms? If yes, please give details on a separate sheet.  Yes  No  
**(This question not applicable in Missouri.)**

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

11. 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

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

13. Do you order or perform diagnostic tests?  Yes  No

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

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

16. Do you perform a physical examination? If "Yes", briefly describe techniques and instruments used:  Yes  No

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17. Do you conduct informed consent discussions?  Yes  No

18. Describe any other procedures, treatments, or duties you perform:

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19. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice.

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20. Please list all states in which you are licensed along with each license number and renewal date:

STATE	LICENSE #	RENEWAL DATE
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

21. Please include copies of the following:
- A. Current Curriculum Vitae.
  - B. Copy of your approved notification of supervision form.
  - C. Copy of current professional liability insurance declarations page.
  - D. Claims history.
  - E. Copies of your practice protocols.

## IMPORTANT! YOU MUST READ CAREFULLY

**COLORADO FRAUD WARNING** - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**FLORIDA FRAUD NOTICE:** 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.

**KENTUCKY FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**NEW JERSEY FRAUD WARNING:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NEW YORK FRAUD WARNING:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**OHIO FRAUD WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA FRAUD WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PENNSYLVANIA FRAUD WARNING:** 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.

**WISCONSIN EXCEPTION:** If the company agrees to be bound under the terms of this application, your policy will be canceled if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application.

### SPECIFIC CONSENT TO CONDITIONS OF CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application - regardless of whether or not I am granted insurance - and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**IMPORTANT:** Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following page of this Application is an *Authorization To Release Information* form which requires your signature. Please read carefully.

## AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by MEDICAL ASSURANCE (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical and professional associations and medical and professional societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for the State of Indiana and any other State in which he has practiced, or resided, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

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

Date: \_\_\_\_\_

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### INSURED PHYSICIAN'S AUTHORIZATION

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

REQUESTED EFFECTIVE DATE: \_\_\_\_\_

SHARED LIMITS COVERAGE

SEPARATE LIMITS COVERAGE

**Note: Separate Limits Coverage is not available for cytotechnologists. Shared Limit Coverage is not available for certified registered nurse anesthetist, nurse midwife, nurse practitioner, optometrist and psychologist.**

**\*\*Coverage will be written on the Claims-Made policy form.**

\_\_\_\_\_  
Signature of Insured Physician/Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name