

**Employed Healthcare Extender
Professional Liability Application for
Claims Made Coverage**



I. – APPLICANT INFORMATION			
Employer’s Name & Address:			
Name of Employee:			
License # / State Certification:		School/Training/Certification & Year of Completion:	
II. – APPLICANT PRACTICE INFORMATION			
Medical Specialty:	<input type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Practice Registered Nurse <input type="checkbox"/> Physician Assistant (Surgical) <input type="checkbox"/> Certified Registered Nurse Anesthetist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Other: _____		
Are you providing services outside your scope of duties for the employer listed above? If “Yes” please provide a description.			<input type="checkbox"/> Yes <input type="checkbox"/> No
III. – COVERAGE REQUESTED			
Effective Date:		Retroactive Date:	
Limits of Liability:	<input type="checkbox"/> Shared Limits Each Claim \$ _____ <input type="checkbox"/> Separate Limits Annual Aggregate \$ _____		
IV. – APPLICANT PRACTICE HISTORY			
Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered or subject to probationary terms?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you now or have you ever had a chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a complaint or claim brought against you for sexual misconduct?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been indicted and/or convicted of a crime other than a minor traffic violation?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or have you ever had a drug or alcohol addiction or dependency or sought treatment for such?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?			<input type="checkbox"/> Yes <input type="checkbox"/> No
V. - PLEASE REVIEW AND SIGN			
<p>I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other firm, or professional association.</p> <p>I understand and agree that any material misrepresentation or omission by me in this application may act to void such insurance and may give the Company a right to rescind such coverage.</p>			
_____ Signature of Applicant			_____ Date
<p>This coverage is issued by a risk retention group. This risk retention group may not be subject to all insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for this risk retention group.</p>			