AMERIPA
PROFESSIONAL LIABILITY INSURANCE
YOUR INDEPENDENT PRACTICE ADVOCATE

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

for a Corporation, Partnership or Professional Association

NOTE
This application is for the Corporation, Partnership or Professional Association requesting professional liability insurance for the applicable entity and should be submitted by the authorized representative purchasing insurance for the entity.

INSTRUCTIONS: Please complete all sections of this form either electronically or in ink. All sections requiring a signature or initials must be signed in ink.

Signed, dated and fully completed application.

Copy of the declaration page from your current malpractice insurance carrier's policy.

"Policy History Reports", "Claim History Reports", or "Loss Runs" covering the past ten years. These may be obtained from your current or prior carrier's).

A copy of your letterhead.

A copy of any advertisements for your services.

If this is an application for professional liability insurance for a claims-made policy form the coverage of this policy is limited to liability only for those claims that: A) arise from incidents or events that happen while the policy is in force and that involve your professional services or the use of your professional office premises, and B) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval. No coverage exists until a binder or Declarations Page, together with any endorsements that may apply, has been issued to the named insured.

Send completed application with associated documentation to:

AMERIPA INSURANCE, INC.
1500 WALNUT AVENUE
ORELAND, PA 19075

(P) 215-233-4410 / 800-466-6906
(F) 215-233-4409
(Email) patlawn@picmedmal.com

If you have any questions regarding the application process or any information contained in this packet, please contact Pat Lawn at (215) 233-4410 or patlawn@picmedmal.com.

Applicant's Signature (All pages must be signed)

Date

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Type of Policy Requested:

_____ Occurrence

_____ Claims Made with Retroactive Coverage / Retroactive Date:____/____/____

_____Claims-Made without retroactive coverage

PRACTICE INFORMATION

_____ _____/_____/_____

Name of Corporation, Partnership or Association — Requested Effective Date

_____ _____

Street Address — Mailing Address (if different)

_____ _____ _____ _____

City — County — State — Zip code

_____ _____

Authorized Contact — Title:

_____ _____ _____

Phone Number and Extension — Fax Number — E-mail Address

_____ _____

Federal Tax ID Number — Web Address

PRACTICE LOCATIONS

Current Office Locations: List all current office or clinic practice locations in this section. Include all locations whether or not insurance is desired at that location. If additional space is required to show more than four practice locations, please attach aseparate sheet or your brochure.

Name of Location	City and State	County	% of practice

If this Corporation is a Surgical Center provide the number of annual procedures:_____

_____ _____

Applicant's Signature (All pages must be signed) — Date

AMERIPA INSURANCE, INC.

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List the names of all physicians, nurse midwives and podiatrists associated with this practice. If additional space is needed, please attach a roster.

	Name	Specialty	Name of carrier if NOT to be insured
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Please list the name of all nurse practitioners, nurse surgical assistants, nurse anesthetists, nurse surgical assistants, opticians, optometrists, perfusionists, physician assistants, physicists, and psychologists associated with this practice. If additional space is needed, please attach a roster.

	Name	Specialty	Name of carrier if NOT to be insured
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Please list the number of other professional employees in your practice:

	Audio/speech pathologist
	Electroencephalogram technician
	Laboratory technician
	Licensed practical nurse
	Medical assistant
	Occupational therapist
	Ophthalmology technician
	Optician

	Physical Therapist
	Registered Nurse
	Surgical Assistant
	Surgical Technician
	X-ray technician
	Social worker
	Other: _____
	Other: _____

_____ _____

Applicant's Signature (All pages must be signed) Date

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INSURANCE HISTORY

You must attach the declarations page from your current policy	Current Policy	First Prior Policy	Second Prior Policy
Insurance Carrier			
Type of policy (Claims-made or Occurrence)			
Effective Date			
Expiration Date			
Retroactive date (Claims-made only)			

If your current policy is a "Claims-Made" policy, you MUST either purchase a Claims-Made policy with prior acts (retroactive) coverage from your new carrier OR obtain a reporting endorsement (tail) from your current carrier.

If you DO NOT WANT or DO NOT NEED prior acts coverage, please indicate this decision by signing in the space provided. By signing, you are acknowledging that your retroactive date of coverage WILL BE THE SAME as your effective date of coverage.	**I decline or don't need retroactive coverage:**
	Applicant Signature

PROFESSIONAL LIABILITY HISTORY

Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer?	Yes	No
Has any claim or suit for alleged malpractice been brought against you in the past ten years?	Yes	No
Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?	Yes	No

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING SECTION:

CASE 1

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case		Status of case			
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

Applicant's Signature (All pages must be signed)

Date

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CASE 2

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case			Status of case		
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

CASE 3

Date of occurrence of event	Date case was filed	Plaintiff's Name	Carrier involved

Your status in this case			Status of case		
	Primary defendant		Pending		Dismissed/dropped
	Co-defendant		Found for plaintiff		Settled, if settled, state amount:
			Found for defendant	Amount:	

Alleged harm to patient:	
Circumstance of patient's illness:	
Any other pertinent details:	

The undersigned agrees to fully comply with the conditions and understands that noncompliance may result in a non-renewal of coverage. The undersigned declares that to the best of his or her knowledge and belief that the statements set forth herein are true. Although the signing of this application does not bind the undersigned on behalf of the applicant or its organization or other insured person to effect insurance, the undersigned agrees that this application and its attachments shall be the basis of the contract should a policy be issued and shall be attached to and form part of this policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

Notice to 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.

Save Application

Print application

Applicant's Signature (All pages must be signed)

Date