AMERIPA
PROFESSIONAL LIABILITY INSURANCE
YOUR INDEPENDENT PRACTICE ADVOCATE

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

For Advanced Practice Providers

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.

CHECKLIST:

- ☐ Signed, dated and fully completed application. Alternatively, you may attach an application for another insurer that you completed within the last 60 days, or attach a current CAQH report. If you submit an alternative application or report, you must still sign and date each page of this application and (i) tell us the number of hours you work each week on page 2; (ii) confirm and sign if you are declining prior acts coverage on page 3; and (iii) complete the Professional Liability History Section beginning at page 4.
- ☐ Provide a current copy of curriculum vitae
- ☐ Provide a copy of the declaration page from your current malpractice insurance policy, if applicable
- ☐ Provide a copy of your current DEA registration, if applicable
- ☐ Provide "policy history reports", "claim history reports" or "loss runs" covering the past ten years (These must be obtained from your prior insurance carrier(s) or broker(s)
- ☐ Provide a copy of your collaborative agreement, if applicable

All attachments are considered to be a part of this application.

If this is an application for a claims-made policy form of professional liability insurance, 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, have been issued to the named insured.

Send completed application and 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

AMERIPA
AMERICAN INDEPENDENT PHYSICIAN ASSOCIATION
PROFESSIONAL LIABILITY INSURANCE

If you have any questions regarding the application process or any information required in this application, please contact the Program Services Department at (215) 233-4410.

PERSONAL INFORMATION

First Name _____ Middle Name _____ Last Name _____ Suffix _____

Degree or Title _____ Date of Birth _____ E-mail _____

Requested Effective Date of Coverage: _____/_____/_____

Type of Policy Requested

____ Occurrence / _____ Claims-Made with Retroactive Date of: _____/_____/_____

____ Claims-Made without Retroactive (prior acts) coverage

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Applicant's Name _____ Effective Date of Coverage _____

PRACTICE INFORMATION

Practice Name _____ Office Phone _____

Corporate Office Address _____ Office Fax _____

City _____ State _____ Zip Code _____

LICENSURE AND CERTIFICATION

I am applying for coverage as a:

_____ Certified Nurse Midwife	_____ Nurse Surgical Assistant	_____ Perfusionist	_____ Registered Nurse
_____ Nurse Anesthetist (CRNA)	_____ Occupational Therapist	_____ Physician Assistant	_____ Radiology Technician
_____ Licensed Practical Nurse	_____ Optician	_____ Psychologist	Other:
_____ Nurse Practitioner (CRNP)	_____ Optometrist	_____ Physical Therapist	_____

PA License Number (If applicable) _____ Additional Certifications _____

WORK SETTING/HOURS

Please check all that apply:

_____ Primary Physician Office	_____ Emergency Department	_____Hospital Operating Suite	_____ Ambulatory Surgery Center
_____ Specialty Physician Office	_____ Trauma Center	_____Hospital In-Patient Unit	_____ Other Outpatient Facility
_____ Psychiatric Facility	_____Nursing Home/Extended Care Facility		

Average hours worked per week

Please indicate the average total hours worked per week for this practice:
(Worked hours includes patient care, hospital rounds, record-keeping, administrative duties, teaching, house-calls, nursing home visits and utilization review)

_____ 10 or less hours _____21-29 hours
_____ 11-20 hours _____ 30 or more hours

SCOPE OF PRACTICE

Please check all that apply:

_____ Assist in surgery	_____Pre or post operative care	_____ Emergency or critical care <10 hrs per week
_____ Diagnostic management	_____Obstetrical care	_____ Emergency or critical care >10 hrs per week
_____ Ordering/interpreting diagnostic testing	_____Prescribe medications	_____ After hours/weekend call
_____ Perform physical assessments	_____Pediatric care	_____
_____ Compile patient histories	_____Anesthesia administration	_____

Applicant's Signature _____ Date _____

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_____
Applicant's Name

HOSPITAL PRIVILEGES

Hospital Name	City, State	Type of Privileges	Specialty or Department

INSURANCE HISTORY

	Current Policy	First Prior Policy
Name of Carrier		
Type of policy	_____Claims-Made _____ Occurrence	_____Claims-Made _____Occurrence
Effective date		
Expiration date		
Retroactive date		

COVERAGE REQUESTED

Type of coverage requested: Limits of Liability requested:

_____ Claims-Made Coverage_____$500,000 per claim/$1,500,000 Annual Aggregate

_____ Occurrence Coverage _____$1,000,000 per claim/$3,000,000 Annual Aggregate*

* Certified Registered Nurse Practitioners and Physicians Assistants are required to obtain limits of $1,000,000/$3,000,000

PRIOR ACTS COVERAGE

If your prior policy is a "CLAIMS-MADE" policy, you must either purchase prior acts (retroactive) coverage through this policy or obtain an extended reporting period endorsement (tail) from your prior 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 do not need retroactive coverage Applicant Signature

ADDITIONAL INFORMATION

Within the past seven (7) years have you been the subject of any complaint, charge or disciplinary action against you for any reason by a court, licensing board, hospital, or regulatory agency responsible for enforcing or maintaining the standards of your profession?	Yes	No
Have you ever had your professional liability insurance declined, cancelled or non-renewed for any reason?	Yes	No
Please provide a brief explanation for either question above:		

_____ _____
Applicant's Signature Date

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Applicant's Name

PROFESSIONAL LIABILITY HISTORY

Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior or current insurer?		Yes		No
Has any claim or suit for alleged malpractice been brought against you in the prior ten (10) 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

Please provide a brief explanation for each situation which requires a "YES" answer to any of the prior three questions:

1.

2.

3.

4.

The undersigned agrees to fully comply with the conditions of insurance 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.

Applicant's Signature

Date

NOTICE TO PENNSYLVANIA 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.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

NOTICE TO SOUTH CAROLINA APPLICANTS: Any person who knowingly and willfully presents false information in an application for insurance may be guilty of insurance fraud and subject to fines and confinement in prison. (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties).

Applicant's Signature _____ Date _____