DOCTORS professional liability

Application for Coverage - Ancillary

I. ANCILLARY INFORMATION

Full Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Professional Designation: ☐ NP/ARN ☐ PA ☐ CNM ☐ RN ☐ LPN ☐ PhD ☐ PT

☐ OD ☐ Other _____

Professional Speciality: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Which is the best way to contact you? ☐ Home ☐ Office ☐ Cell Phone

II. EMPLOYER INFORMATION

Name of the Employer: _____

Office Address: _____

Street: _____ City: _____ County: _____

State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Office Email: _____

Other practice locations: _____

Website(s): _____

III. EDUCATION/TRAINING

School/Facility: _____ Location: _____

Date Admitted: _____ Date Completed: _____

Degree: _____

Certification(s) held: _____ Year recertified: _____

Are you a member of an affiliated professional organization?

If so, please indicate: _____

IV. MEDICAL LICENSURE

State: _____ License #: _____ Expiration Date: _____

State: _____ License #: _____ Expiration Date: _____

V. CURRENT PRACTICES

a. Average number of hours worked per week?

_____

Do you moonlight (work outside the control of your employer)? ○ Yes ○ No

If yes, where: _____

b. Work Setting: _____

c. Scope of Practice (Check all areas that apply.)

- ☐ Addiction Medicine
- ☐ Outpatient
- ☐ Inpatient
- ☐ Gynecology/Prenatal Care
- ☐ Alternative/Complementary Medicine Service
- ☐ Pediatric Care
- ☐ Behavioral Health Care
- ☐ Performance of Minor Surgery/Assistance in Surgery
- ☐ Dermatology/Aesthetic Procedures
- ☐ Prescribe/Dispense Controlled Substances
- ☐ General Practice/Exams/Diagnostics
- ☐ Specialist Referral

d. Work Setting

- ☐ Correctional Facility
- ☐ MedSpa
- ☐ Long Term Care Facility
- ☐ Physician's Office
- ☐ Urgent Care Facility
- ☐ Other: _____

VI. PREVIOUS INSURANCE

Please provide ten (10) years of previous insurance information: _____

_____

Current Carrier: _____

Effective date: _____ Expiration date: _____ Retroactive date: _____

Limits of Liability: _____ Type of Coverage Premium: _____

VII. CLAIMS INFORMATION (For the past 10 years)

Has any claim or suit for alleged malpractice ever been brought against you? ○ Yes ○ No

Are you aware of circumstances that might reasonably lead to such a claim or lawsuit? ○ Yes ○ No

If yes, please complete a claim supplemental for each claim and provide prior carriers loss history.

Total Number of Claims: _____ Open / Reserve: _____ Closed: _____

Any change in your practice as a result of claims? _____

VIII. ADDITIONAL BACKGROUND

(Check all that apply): Have you ever?

Had your license or certification investigated, suspended, revoked restricted, or placed under probation in any state?	○ Yes	○ No
Had your DEA license revoked, limited, refused, suspended or denied?	○ Yes	○ No
If yes, give details: _____		
Had your professional liability insurance declined, suspended, non-renewed or canceled? (Not Applicable to Missouri Applicants.)	○ Yes	○ No
Had any complaints filed against you with a hospital, regulatory or certifying authority?	○ Yes	○ No
Been treated or hospitalized for mental or emotional disorder?	○ Yes	○ No
Been charged with or convicted of a felony or misdemeanor other than minor traffic violations?	○ Yes	○ No
Been treated for (or recommended treatment for) alcoholism, sexual or drug addiction?	◉ Yes	◉ No

IX. LIMITS OF LIABILITY REQUESTED

Please select one or more: ☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000
☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

Requested Effective Date: _____ Requested Retroactive Date: _____

Are you purchasing tall coverage from your current carrier?	○ Yes	○ No
If yes, please provide DPL with a copy.		

WARRANTY:

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy. I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and which I was aware, or should have been aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy. Any binder of coverage issued by DPL Insurance Company (Company) as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection Regulations. Further, I acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/ or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source. I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence and qualifications.

Acknowledged and Agreed: _____

Signature of Applicant: _____ Date: _____

Signing this application does not bind the Company to complete the insurance. All information requested in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information.

FRAUD WARNINGS: _____