ISMIE Mutual Insurance Company
The Physician-First Service Insurer

ATTN: UNDERWRITING DIVISION

Twenty North Michigan Avenue
Suite 700
Chicago, IL 60602
Telephone 312-782-2749
Toll Free 800-782-4767
Fax 312-782-2023
www.ismie.com

BR-3900 (09/16)

Processing Number _____

Application for Non-Physician Professional Liability Insurance

□ Separate Limits
□ Shared Limits*

Claims-Made

"A claims-made policy is limited to claims which are first made while the policy is in force and arise out of professional services provided on or after the retroactive date stated in the Declarations page, and as defined in the policy."

Instructions: This application should be completed by Allied Health Personnel including: Certified Registered Nurse Anesthetists, Certified Clinical Nurse Specialists, Certified Nurse Practitioners, Certified Nurse-Midwifes, Physician Assistants and Psychologists, as well as Dentists, Optometrists and Pharmacists. An Individual Physician application is required for Chiropractors and Podiatrists. It is essential that all statements be completed and all questions answered. If the answer to any question is "**no**", be certain to check "**no"** on the Application. **Please do not leave any question unanswered. If additional space is required to answer any question, use the "Remarks Addendum" section. *Only separate limits are available in states with a Patient Compensation Fund.**

1. Applicant Name:

First Middle Last Title

☐ Male ☐ Female

2A. Name of ISMIE Mutual Insured Employer:

Name Policy Number

2B. Indicate all states of practice where ISMIE Mutual coverage is desired:

3. Desired effective date of coverage (12:01 a.m. Standard Time):

___ / ___ / ___

Month Day Year

4. Desired retroactive date (for prior acts coverage only - 12:01 a.m. Standard Time) ***Applicable to separate limits only*:**

___ / ___ / ___

Month Day Year

Non-Physician General Information

5. Date of Birth: _____ **6. Social Security Number:**_____

7. Home Address: _____

_____

City: **State:** **Zip Code:**

Telephone: ( ) - Fax: ( ) - E-Mail Address:

8 a. Professional Designation (i.e. Nurse Practitioner, Certified Nurse Midwife, etc.)**:**_____
Please provide a copy of your current job description; and provide a copy of your collaborative agreement(s) (if applicable).

8 b. License Number:_____
(include copy of license) State:_____

8 c. Professional Certification(s):_____

9 a. Mailing Address:
Note: This address is where all of your insurance documents and correspondence will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

9 b. Billing Address: **Same as 9a.** ☐
Note: This address is where all of your insurance premium invoices and notices will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

10. Previous Insurance Carriers - Last five (5) years:*

Carrier Name	Policy Period	Limits	Claims-Made	Occurrence
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

***It is necessary that you obtain a current Loss History from each carrier listed above.**

11. Training Completed:_____ **Year Graduated:**_____

Name of Facility/Institution

_____ **Degree:**_____

City **State** **Country**

12. A. Additional Training
Name of Hospital/Facility:

_____

_____

City **State** **Country**

Type of Training:_____

From: _____ **To:** _____
mo./yr. **mo./yr.**

Completed: ☐ **Yes** ☐ **No**

B. Additional Training
Name of Hospital/Facility:

_____

_____

City **State** **Country**

Type of Training:_____

From: _____ **To:** _____
mo./yr. **mo./yr.**

Completed: ☐ **Yes** ☐ **No**

13. Previous Professional Experience since Completion of Formal Training

City, State, Country	From Month /Year	To Month/Year	Practice Activity/ Employer	Carrier

14. Policy Limits

☐ **$500,000/$1,500,000*** ☐ **$1,000,000/$3,000,000** ☐ **$2,000,000/$4,000,000**
(will be separate from your employer's, but must be equivalent to your employer's)

***NOTE: These limits are only available in Illinois.**

☐ **Shared Limits (will be shared with your employer)**

Please skip this section if you practice in a state with a Patient's Compensation Fund

15. Practice Information

List all current Office/Outpatient Practice Locations in this section. Include all locations whether or not ISMIE Mutual insurance is desired at that location. Please indicate additional locations on the "Remarks Addendum" section. Please include facility code(s) to identify all that are applicable.

Facility Codes (Please indicate all that apply)

01- Physician Office
02- Hospital
03- Extended Hour Walk-In Clinic
04- Surgicenter
05- Day Spa / Medi-Spa
06- Nursing Home/Extended Care Facility
07-HMO, IPA, PPO
08-Urgent Care Center
09-Clinic with overnight stays
10-Industrial Clinic
11- Government Location
12-Weight Reduction Clinic
13-Pharmacy
14-Abortion Clinic
15-Drug Control Clinic
16-Commercial Laboratory
17-Other

A. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

B. Office Name: _____

Facility Code: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____

Is this your primary office location? **Yes** ☐ **No** ☐

Distance from Home: **Miles** _____ **Minutes** _____

Do you own or operate a Pharmacy at this location? Yes ☐ **No** ☐

If "Yes", indicate the name of the company that provides Druggist Liability/Pharmacist Liability Insurance.

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ **No** ☐

If "No," describe activity not to be covered and state by whom insured:

_____

_____

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, consultations, and in hospital on-call time.**

_____.

16. **Do you maintain hospital privileges at one or more facilities? Yes ☐ No ☐**
If yes, please complete section A and B (please copy this page for additional hospital locations)
If you do not maintain hospital privileges, please explain in the "Remarks Addendum" section.

A. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____ **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes ☐ Classroom ☐ Clinical ☐**

Do you provide services in the ER at this hospital?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: Yes ☐ No ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, etc.**

Distance from Home: **Miles** _____ **Minutes** _____

B. Hospital Name: _____

Address: _____

Suite/Room Number: _____

City, State, Zip: _____

County: _____ **Telephone:** _____ **Fax:** _____

Category of privileges (active, consulting, etc.) _____

Specialty department of: _____

Do you teach at this hospital? **Yes ☐ Classroom ☐ Clinical ☐**

Do you provide services in the ER at this hospital?

Yes ☐ No ☐

If "Yes", average number of hours weekly: _____

Is this location a Nursing Home or Extended Care Facility?

Yes ☐ No ☐

Is ISMIE Mutual Insurance desired for this location?

Yes ☐ No ☐

If "no," describe activity not to be covered and state by whom insured:

_____

Is this your primary hospital location?: Yes ☐ No ☐

Average number of patients per week: _____

***Average weekly practice time at this location:** _____

***Base your answer on time devoted to all clinical patient care including completion of medical records, etc.**

Distance from Home: **Miles** _____ **Minutes** _____

17. Describe practice activities, including any procedures performed:

18. Profile Questions (Include details to each question in the "Remarks Addendum.")

YES	NO	
☐	☐	a. Has your professional liability insurance ever been canceled for non-payment, declined, non-renewed, or issued on terms (including, but not restricted to: restrictive endorsements, surcharged premium, other underwriting action etc.)? **(Not Applicable in Missouri)**
☐	☐	b. Have you treated any patients by means of any therapeutics which could be considered unconventional, experimental, investigational or clinical research that is not within the scope of research protocols approved by the Food and Drug Administration (FDA) or an institutional review board (IRB) (also known as an independent ethics committee (IEC), an ethical review board (ERB) or a research ethics board (REB))? If "Yes", utilize the "Remarks Addendum" on page 11 to provide a full written narrative indicating treatment(s), and provide name(s) and address(es) of sponsoring institution(s) or entity(ies) if applicable.
☐	☐	c. Have any of your hospital privileges ever been denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or have you ever been subjected to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry?
☐	☐	d. Have you ever been subjected to probation, suspension, reprimand, censure, sanction or other disciplinary action as a result of any governmental agency, medical or professional society disciplinary or administrative proceedings?
☐	☐	e. Has membership in any medical society or professional organization ever been denied, suspended, revoked, voluntarily surrendered or accepted on a restricted basis?
☐	☐	f. Have you ever been convicted of an act committed in violation of any law, statute or ordinance, including a conviction for driving while intoxicated (DUI), excluding other traffic offenses?
☐	☐	g. Has your license to practice medicine or prescribe controlled substance ever been suspended, revoked, voluntarily surrendered, reprimanded, fined or subjected to probationary terms? If "Yes", indicate which:
☐	☐	h. Have you ever incurred, become aware of having, or had an allegation made against you of having any illness or physical disability that impairs or potentially could impair your ability to practice medicine or your specialty including but not limited to: alcoholism, substance abuse, mental illness, degenerative diseases of the central nervous system, organic brain disease, convulsive disorders, multiple sclerosis, rheumatoid arthritis, infectious disease, etc.?
☐	☐	i. Has any malpractice claim or suit been brought against you within the past five (5) years? If "Yes", please complete the Claim Information Supplement for each claim/suit brought against you in the past and submit complete copies of all office/hospital records, summons and complaint, etc.

Certificate(s) of Insurance

19. If your insurance request is accepted, as a service to its members, ISMIE Mutual can provide evidence of your coverage on an automated basis to a hospital, employer, etc. by issuing a Certificate of Insurance. If you wish to have a Certificate of Insurance issued to a **third party**, please complete the following:

Name of Certificate Holder

Street Address

City **State** **Zip**

Please check one:

- ☐ **Medical Director**
- ☐ **Medical Staff Office**
- ☐ **Administrator**
- ☐ **Other** _____

Specific Policy Limits will be printed on Certificate.

Name of Certificate Holder

Street Address

City **State** **Zip**

Please check one:

- ☐ **Medical Director**
- ☐ **Medical Staff Office**
- ☐ **Administrator**
- ☐ **Other** _____

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

PROXY

By applying for and receiving coverage from ISMIE Mutual Insurance Company, the policyholder/member agrees to grant, assign, and give a proxy to the Board of Directors of ISMIE Mutual Insurance Company or their designee, for purpose of casting a vote at any and all meetings or in any and all instances in which a vote of the policyholders/members is required. It is understood that in the absence of any further action by the policyholder/member, this proxy shall remain valid and binding for the length of time which the policyholder/member shall continue to be a policyholder/member of ISMIE Mutual Insurance Company. It is further understood that on any given issue as to which policyholders/members shall have a right to vote the policyholder/member may, by indicating in writing his, her, or its desire, revoke this proxy for purposes of the issue or matter then pending a vote. In the instance in which the policyholder/member revokes this proxy, he, she, or it may then vote in person or by written proxy at any meeting called for the casting of said vote. At the conclusion of said vote, this proxy, given to the ISMIE Mutual Board of Directors or its designee, shall return to full force and effect and shall continue in full force and effect unless and until the policyholder/member elects to revoke this proxy for purposes of a future issue which may arise.

Applicant's Name (please print)	**Applicant's Signature**	**Date**

REPRESENTATION

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of ISMIE Mutual in considering this application have been omitted. *I agree that this shall be the basis of the policy of insurance requested and that I will notify ISMIE Mutual of any changes contained herein.*

FRAUD NOTICE (applicable in Kentucky only)

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 act, which is a crime.

HIPAA DISCLOSURE

ISMIE Mutual Insurance Company and its affiliates shall act as business associates of applicant(s) with respect to the receipt, use and disclosure of protected health information. The Business Associate Agreement is hereby incorporated by reference.

AUTHORIZATION

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, ISMIE Mutual or its duly authorized representative may conduct an inquiry or investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant for this insurance. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, my/their insurance agents or consultants, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physician, any prior insurance carriers and ISMIE Mutual, or its duly authorized representative. I hereby release and discharge the aforementioned providers of information, ISMIE Mutual, its duly authorized review committee from any and all legal liability which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by ISMIE Mutual or its duly authorized representative**.** I authorize ISMIE Mutual or its duly authorized representative to provide information regarding my professional liability history and to issue Certificates of Insurance to those hospitals, managed care entities or other organizations to which I am affiliated or have applied. I consent and agree to the exchange of information regarding my professional liability policy between my present/future employer and ISMIE Mutual or its duly authorized representative. In the event that my insurance premiums are paid by my present/future employer and the practice relationship between myself and my employer is severed at any time during the policy period for any reason, including but not limited to cancellation of my policy, it is agreed that any and all remaining insurance premiums, including any return premium due, as of the severance date of the practice relationship, shall be the property of the employer. Communication regulations require that certain entities, including ISMIE Mutual and its affiliates, obtain written consent to share or distribute policyholder information via regular mail, e-mail, and facsimile. By signing this consent and authorization, you are agreeing to receive promotional notices or solicitation of the availability of goods, services, membership, and opportunities related to the practice of medicine from ISMIE Mutual and its affiliates.

Applicant's Name (*please print*)	Applicant's Signature	Date
Employer's Name (*please print*)	Employer's Signature	Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor to offer insurance to the applicant.

A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original.

Insurance Agent/Producer/Broker (*please print*)	Signature	Date

Claim Information Supplement (please print).

In addition to completing this form, please provide a typed, detailed narrative for each open claim, or any claim that has closed with an indemnity payment. Please photocopy this form for additional claims.

1. Patient/Claimant

_____
Name **Age** **Sex**

2. Date(s) of treatment and/or surgery which led to the allegations against you: _____

3. Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state** _____ _____
Month **Year**

4. Name of insurance carrier defending you: _____

5. Policy Number: _____

6. Names of other doctors and hospitals, if any, involved in claim or suit: _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $**_____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made. Indicate amount of settlement or award:**

a. Your policy $ _____ **Date**

b. Total (if additional defendants involved) $ _____

---

1. Patient/Claimant

_____
Name **Age** **Sex**

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state** _____ _____
Month **Year**

4. Name of insurance carrier defending you: _____

5. Policy Number:_____

6. Names of other doctors and hospitals, if any, involved in claim or suit: _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $**_____

- Has carrier indicated desire to settle?

☐ **Yes** ☐ **No**

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made. Indicate amount of settlement or award:**

a. Your policy $ _____ **Date**

b. Total (if additional defendants involved) $ _____

Remarks Addendum (please print)

Question Number	Remarks

BR-3900 (09/16)