

APPLICATION FOR ANCILLARY PERSONNEL PROFESSIONAL LIABILITY INSURANCE AS ADDITIONAL NAMED INSURED

PLEASE TYPE OR PRINT RESPONSES AND ANSWER ALL QUESTIONS. COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETE.

COVERAGE REQUESTED TO COMMENCE 12:01 AM ON _____ (MO/DAY/YR)

Named Insured: _____ **Policy Number** _____ (For UMIA use only)

1. NAME AND ADDRESS OF ADDITIONAL NAMED INSURED

First	Middle	Last	Title
Home Address	City/State	Zip	Home Phone
Date of Birth	State/Lic. Number/Type	Soc. Sec. #	

2. EMPLOYMENT INFORMATION

Location of Employment

Doctors Office
 Hospital
 Clinic
 Home
 Dental Office
 Other
 Please specify: _____
 Number of hours worked per week: _____

3. TYPE OF PROFESSION

Nurse Anesthetist
 Nurse Midwife
 Physician Assistant
 Nurse Practitioner
 LPN
 Registered Nurse
 Surgical Nurse
 Pump Perfusionist
 Lab Technician
 Dental Tech
 Other
 Please specify: _____
 COVERAGE IS RESTRICTED TO SERVICES PERFORMED UNDER THE EMPLOYMENT AND UNDER THE DIRECT SUPERVISION OF THE NAMED INSURED.

4. CERTIFICATION INFORMATION

The applicant graduated from: _____

State any degree or certification involving your occupation: _____

State any special licenses or certificates required by any federal, state or local municipality: _____

Has the applicant ever:

Been subject to a disciplinary or investigative proceeding or reprimanded by a governmental or administrative agency, hospital or professional association?
 Yes No
 Had any mental illness?
 Yes No
 Had any chronic illness or physical defect?
 Yes No
 Abused alcohol or drugs?
 Yes No
 Been convicted of any misdemeanor or felony (other than minor traffic violations)?
 Yes No
 Had restrictions on his/her license?
 Yes No

5. PRACTICE INFORMATION

Does the applicant render professional services directly to patients? Yes No

Describe these services: _____

Does the applicant perform or assist in surgery? Yes No

Does the applicant prescribe or dispense any drugs with the counter-signature of a physician? Yes No

Is the applicant employed or under contract with any other individuals or entity other than the named insured? Yes No

Please list: _____

6. INSURANCE INFORMATION

Has the applicant ever been canceled or declined coverage for malpractice insurance? Yes No

Are you aware of any circumstances which may result in any suit or malpractice claim being made or brought against the applicant? Yes No

Give details:

Please indicate name and policy number of prior or current carrier:

Name Policy Number

Occurrence Claims-Made Retroactive Date: _____

Reporting Form Endorsement ("Tail") purchased? Yes No

PLEASE NOTE:

No coverage for prior acts will be provided unless approved by UMIA.

When an employed ancillary person is named as an Additional Named Insured on the policy of the individual physician, the individual physician shares his/her limit of liability with the employed ancillary person. In the event a claim is made against both the individual physician and the employed ancillary person arising from the same loss, the limit of liability is the same as though a claim had been made against the individual physician only.

I certify that the foregoing information is true and correct and I authorize release and exchange of information involving either underwriting or claims matters between all prior insurance carriers and the UMIA. I further authorize UMIA to obtain a copy of my hospital privileges if not enclosed, secure reports directly from hospitals involving situations with potential liability, and obtain information regarding disciplinary procedures by specialty societies and the state licensing board.

I certify that I know of no claims, suits or occurrences presently pending which have not been reported to my previous carrier. The limit of liability provided will be a shared limit with the Named Insured. No additional limits apply.

Signature - Additional Named Insured

Date