

## INDIVIDUAL APPLICATION FOR ANCILLARY PERSONNEL

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)

### 1. NAME AND ADDRESS

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

### 2. 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: \_\_\_\_\_

### 3. 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: \_\_\_\_\_

### 4. EMPLOYMENT INFORMATION

(Location of Employment)

Doctors Office       Hospital       Clinic  
 Dental Office       Other      Please specify: \_\_\_\_\_

Employed by: \_\_\_\_\_

### IMPORTANT

**COVERAGE IS RESTRICTED TO SERVICES PERFORMED WHILE EMPLOYED AND UNDER THE DIRECT SUPERVISION OF A UTAH MEDICAL INSURANCE ASSOCIATION INSURED PHYSICIAN OR CLINIC.**

### 5. PRACTICE INFORMATION

Do you render professional services directly to patients?       Yes       No

Describe these services: \_\_\_\_\_

Do you perform or assist in surgery?       Yes       No

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

Are you employed or under contract with any other individuals or entity other than the insured physician or clinic?       Yes       No

Please list: \_\_\_\_\_

Are you entering private practice for the first time?

Yes  No

Number of hours per week involved in direct patient care: \_\_\_\_\_

Please list all office locations for which you are requesting coverage. List principal location first.

Number	Street	Suite	City	State	Zip	Phone
Number	Street	Suite	City	State	Zip	Phone
Number	Street	Suite	City	State	Zip	Phone

**6. Please answer the following questions. If any are answered "Yes," please attach complete details on a separate sheet.**

Have you 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 your license?

Yes  No

**7. PROFESSIONAL LIABILITY COVERAGE**

Limits of Liability desired: (Limits indicated are Each Loss Limit and Aggregate Limit)

\$100,000/\$300,000

\$500,000/\$1.5 Mil

\$1 Mil/\$3 Mil

\$2 Mil/\$4 Mil

\$3 Mil/\$5 Mil

\$4 Mil/\$6 Mil

\$5 Mil/\$7 Mil

**8. BILLING MODE DESIRED**

Annual

Semi-Annual

Quarterly

Monthly

(Only monthly billing mode carries an interest charge)

**9. INSURANCE INFORMATION**

Have you 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

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

\_\_\_\_\_  
Name

\_\_\_\_\_  
Policy Number

Occurrence

Claims-Made

Retroactive Date: \_\_\_\_\_

Are you making application for Prior Acts coverage?

Yes  No

**PROFESSIONAL PREMISES LIABILITY COVERAGE**--Office based ancillary personnel will be required to purchase Professional Premises Liability Insurance. If purchased through UMIA, Limits are equal to the Professional Liability Limits selected up to \$1 million/\$3 million. In addition, property damage of \$50,000 each occurrence and premises medical payments of \$1,000 per person up to a maximum of \$3,000 per year, and \$25,000 each accident are included. UMIA does not underwrite coverage for office contents or personal property.

**10. CLAIM INFORMATION:**

Please TYPE all claim information. Failure to provide complete information as requested will result in delays in processing your application for insurance. If an incident was reported by you but no claim was made or suit filed, it is not necessary to provide information. **ALL SUCH INFORMATION SUPPLIED WILL BE TREATED IN A CONFIDENTIAL MANNER.**

a. Have you been involved in a claim or suit in the past ten years?  YES  NO

If "Yes," please provide a narrative description of the medical facts of each such claim or suit on a separate sheet. This narrative must include, but not be limited to, the following:

1. Age and sex of patient/claimant.
2. Date(s) and type(s) of treatment and/or surgery which led to the allegations against you.
3. Nature of allegations in claim or suit.
4. Specify whether a suit was ever filed.
5. Names of other health care providers and hospital, if any, involved in claim or suit.

6. Disposition or current status of suit:

Open  Closed

If closed, was payment made?  YES  NO

If payment was made from your policy, state amount: \$ \_\_\_\_\_

If additional defendant was involved, state amount: \$ \_\_\_\_\_

If suit occurred within the last five years, please document the above with complete copies of hospital and office records.

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 of 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.

\_\_\_\_\_  
Name/Signature

\_\_\_\_\_  
Date

IN THE EVENT YOUR POLICY IS CANCELED, EITHER BY YOU OR UMIA, YOU WILL HAVE THE RIGHT TO PURCHASE THE EXTENDED REPORTING FORM ENDORSEMENT "TAIL" COVERAGE. THIS ENDORSEMENT EXTENDS THE PERIOD FOR REPORTING OF CLAIMS ARISING FROM MEDICAL INCIDENTS WHICH OCCUR SUBSEQUENT TO YOUR POLICY'S RETROACTIVE DATE, AND PRIOR TO IT'S CANCELLATION DATE. YOU MUST EXERCISE THIS RIGHT WITHIN SIXTY DAYS FOLLOWING CANCELLATION, BY FULL PAYMENT OF THE PREMIUM.