West Virginia Board of Risk & Insurance Management

PROFESSIONAL LIABILITY INSURANCE APPLICATION

Name of applicant			
Applicant address (*street, city, state, zip*)			
Applicant business address (*street, city, state, zip*)			
County	Home/Business Phone Numbers		Home/Business Fax Numbers
Date of birth	Social Security No.		FEIN
D.E.A. Lic. No.	Current carrier		
Policy Number	Existing form of Insurance ☐ Occurrence ☐ Claims-made	Effective date of coverage	Retroactive date used by your existing carrier
If Claims-made did you purchase an extended reporting endorsement from your current carrier? ☐ Yes ☐ No		Are you applying for prior acts coverage? ☐ Yes ☐ No	

Type of practice
☐ Individual ☐ Employee ☐ Independent Contractor ☐ Owner ☐ Partner ☐ Other

Coverage Limit Sought: $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐

List all Professional Corporations, Professional Associations and Partnerships and other health care related services in which you have ownership.

Name	Description of your interest	% of your practice

If employed, name of employer

If you as an individual, employ or contract medical professionals - complete a, b and c.

a. Number of employed or contracted:

	physicians or surgeons
	physician or surgeon assistant
	nurse midwives
	nurse anesthetists
	nurse practitioners

b. Current insurers – include policy numbers

c. If you, as an individual, employ or contract other medical professionals to provide services, list them and their professional occupations (i.e., R.N., L.P.N., etc.) [*use additional sheets as necessary*]

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Do you wish for us to include your partnership or professional corporation as an additional insured? ☐ Yes ☐ No	
Are you a dues paying member of a professional organization? If so, please specify:	

Professional school attended	Degree	Month	Year
If so recognized by your profession, what is your specialty and subspecialty?			
Are you certified by an approved specialty board? ☐ Yes ☐ No	Name of Specialty Board		

Name all places where you have practiced your profession in the last five years.

	During years

List all states where you are licensed to practice and license numbers.

State	License No.	% of Patients seen, examined or treated in each state

How many scheduled patients do you see per week? _____ How many walk-in patients do you see per week? _____	How many hours do you work per week? _____
Has there been any change in your practice or specialty in the past five years? ☐ Yes ☐ No	Change of specialty
Change of status – full time to part time ☐ part time to full time ☐	Other

Name and location of all hospitals where you hold privileges:

Name	Location

1. a. Are you employed full time by the Federal Government or are you in the military service? ☐ Yes ☐ No
   b. Are you engaged in any "moonlighting " activities? ☐ Yes ☐ No
   if yes, number of hours per month spent moonlighting _____
   c. Has your professional license been suspended, restricted, revoked, or voluntarily surrendered, or has probation ever been invoked? ☐ Yes ☐ No
   d. Have you ever been denied a medical license or been denied certification by a specialty board? ☐ Yes ☐ No
   company to do reviews? *if yes, % of practice*_____ ☐ Yes ☐ No
   e. Are you currently under contract to supervise or administrate any departments within a hospital or other facility, for an HMO or PPO, or any governmental agency or program? ☐ Yes ☐ No
   g . Do you provide any diagnostic, consulting or other professional services to patients in states other than those in which you are currently licensed? ☐ Yes ☐ No
   h. Have you ever had any claims of sexual misconduct made against you? ☐ Yes ☐ No

2. Have any claims or suits ever been made or brought against you? ☐ Yes ☐ No
   Indicate number of previous and/or pending claims or suits _____

3. Do you have any knowledge of any claims which might be made against you or activities that might give rise to a claim? (include any requests for medical records.) ☐ Yes ☐ No

Explain any "yes" answers to questions 1,2, and 3 immediately above. [*use additional sheets as necessary*]

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS COMPLETE, ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MISREPRESENTATIONS IN THIS APPLICATION MAY RESULT IN CANCELLATION OR RESCISSION OF COVERAGE. I UNDERSTAND AND AGREE THAT MY POLICY MAY BE ASSIGNED, INDIVIDUALLY OR COLLECTIVELY, PURSUANT TO STATUTE, TO A THIRD PARTY IF THE THIRD PARTY COVERAGE IS COMPARABLE, AS DETERMINED BY THE WEST VIRGINIA BOARD OF RISK AND INSURANCE MANAGEMENT. I FURTHER AGREE TO REMIT PREMIUMS FOR COVERAGE IN A TIMELY MANNER IF COVERAGE IS PROVIDED THROUGH THE WEST VIRGINIA BOARD OF RISK AND INSURANCE MANAGEMENT AND UNDERSTAND THAT FAILURE TO PAY SUCH PREMIUM IN A TIMELY AGREED MANNER MAY RESULT IN CANCELLATION OF COVERAGE.

Applicant Signature _____ Date _____