

OHA INSURANCE SOLUTIONS, INC.  
155 EAST BROAD STREET  
COLUMBUS, OHIO 43215

APPLICATION FOR ALLIED PERSONNEL  
CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

IMPORTANT: You are applying for Claims Made Coverage. For your own protection, report to your CURRENT insurer BEFORE THE CURRENT POLICY EXPIRES ANY:

Incident with might lead to a claim;  
Request for medical records;  
Unfavorable result in treatment;  
Knowledge of a patient or family member who might consider bringing a claim against you.

THIS APPLICATION WILL BE ATTACHED TO AND FORM A PART OF YOUR POLICY  
If space is insufficient for a complete reply, please attach a separate sheet.  
PLEASE TYPE OR PRINT LEGIBLY

**I. GENERAL INFORMATION**

This application is for:  Certified Nurse Midwife  Certified Registered Nurse Anesthetist  
 Nurse Practitioner  Physician Assistant  
 Other: \_\_\_\_\_

1. Desired effective date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Name: \_\_\_\_\_ First Middle Last Suffix: \_\_\_\_\_ Title: \_\_\_\_\_  
Jr./Sr./III

3. Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

4. Principal Office: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Other office address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Home address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

5. Name of employer or contracted with: \_\_\_\_\_ Policy #: \_\_\_\_\_

6. Supervising Physician, if any: \_\_\_\_\_

## II. EDUCATIONAL BACKGROUND

7. School : \_\_\_\_\_ Degree: \_\_\_\_\_ from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name City State

8. Additional Education: \_\_\_\_\_ Degree: \_\_\_\_\_ from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name City State

9. State(s) where currently licensed:

a. \_\_\_\_\_ # \_\_\_\_\_ Date of License: \_\_\_\_\_ Expiration: \_\_\_\_\_ % of Practice: \_\_\_\_\_  
b. \_\_\_\_\_ # \_\_\_\_\_ Date of License: \_\_\_\_\_ Expiration: \_\_\_\_\_ % of Practice: \_\_\_\_\_  
c. \_\_\_\_\_ # \_\_\_\_\_ Date of License: \_\_\_\_\_ Expiration: \_\_\_\_\_ % of Practice: \_\_\_\_\_

If any of your licenses are or have been inactive, suspended, restricted, or revoked, please explain:

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## III. PRACTICE HISTORY

10. Where have you practiced your profession for the past ten (10) years other than your current practice? Please explain any gaps in your practice. Use Remarks Section for additional locations.

a. Entity Name & Address: \_\_\_\_\_ from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

b. Entity Name & Address: \_\_\_\_\_ from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

c. Entity Name & Address: \_\_\_\_\_ from \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## IV. MISCELLANEOUS

If you answer yes to any of the following questions, please give full details on a separate sheet, include dates, and attach copies of related documents.

11. Have you ever voluntarily surrendered or otherwise restricted any state license?.....  Yes  No
12. Has any state license been refused, restricted, suspended or revoked? .....  Yes  No
13. Has any hospital ever restricted or revoked your privileges or invoked probation for any cause other than incomplete charts? .....  Yes  No
14. Has any hospital ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital? .....  Yes  No
15. Are you now on probationary status?.....  Yes  No
16. Have you ever been treated for alcoholism, mental illness or narcotics addiction? .....  Yes  No
17. Do you have any personal health problems that might affect your practice? ...  Yes  No
18. Have you ever been charged with or convicted of a violation of a federal, state or local law other than minor traffic offenses? .....  Yes  No
19. Have you ever had professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with special surcharge, issued on any special terms or had renewal refused? .....  Yes  No
20. Have you ever been suspended, restricted, or put on probation by any government health program (e.g. Medicare)? .....  Yes  No
21. Do you have any employment contract?  Yes  No If yes, do you:  Observe  Assist  Other \_\_\_\_\_
22. Does your employment/practice require you to practice in the operating room?  
 Yes  No If yes, do you:  Observe  Assist  Other \_\_\_\_\_

Please provide a brief description of your general duties: \_\_\_\_\_

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**V. CLAIMS, INCIDENT AND INSURANCE HISTORY**

23. List professional liability insurers for the past 10 years:

Company	Policy Number	Limits	From	To	Type of coverage form?	
					Occurrence	Claims Made
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

If current policy is Claims Made, are you applying for retroactive (nose) coverage?  Yes  No

If YES, attach a copy of the prior carrier's declarations page and fill in the retroactive date here \_\_\_\_\_  
 If NO, attach a copy of your prior carrier's extended reporting endorsement (tail).

Have you EVER had a claim (demand for money or services) or a suit for alleged malpractice?  Yes  No

Have there been any cases in the last 10 years:  
 that involve your misdiagnosis, which might result in a claim?.....  Yes  No  
 that involve brain damage, quadriplegia, paraplegia, loss of major function?.....  Yes  No  
 with injury that could involve lifelong care or fatal prognosis?.....  Yes  No  
 with an unfavorable or adverse result in which a patient or his/her family was upset and/or  
 threatened legal action?.....  Yes  No  
 where you feel a patient may bring suit for procedure or treatment rendered?.....  Yes  No

**IF YES TO ANY OF THE ABOVE, COMPLETE CLAIM/INCIDENT REPORT (FORM A) FOR EACH INCIDENT AND ATTACH IT TO THIS APPLICATION.**

Was each incident reported to your professional liability insurance carrier? .....  Yes  No

If the incident was not reported to your professional liability insurance carrier, include an explanation on Form A in the following space.

I have listed all claims known to me, or of which I should reasonably be aware, which would arrive from my acts or omissions that have occurred since the retroactive date requested.....  Yes  No

Coverage will not be provided by the Company for known incidents or claims described above, on Form A or any attachments.

**THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF YOUR POLICY.**

I hereby represent the truth of my statements and reasons mentioned in this application and any attachments, and that I have not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application for professional liability insurance. I agree to notify the Company of any change in the information contained in this application. I further agree to be bound by the underwriting guidelines of the Company.

Acceptance of advance payment does not bind the Company to provide insurance.

I acknowledge that I am responsible for payment of all unpaid premiums, regardless of whether anyone has agreed to pay premiums on my behalf.

I authorize release and exchange of information involving past or future underwriting and claims matters, including but not limited to investigations for material information on my reputation and fitness to practice medicine.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

An underwriter may contact you for further information or clarification.

ALLIED PROFESSIONAL CLAIM/INCIDENT REPORT

**If there has been more than one claim, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).**

- 1. Patient's name: \_\_\_\_\_
- 2. Date reported to insurance company: \_\_\_\_\_
- 3. Name of Insurance Company: \_\_\_\_\_
- 4. Date of incident and your treatment: \_\_\_\_\_
- 5. Allegations: \_\_\_\_\_

6. What is the present condition of the patient?: \_\_\_\_\_

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? YES  NO

8. Status of claim (check applicable answer)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Suit threatened, no action taken   | <input type="checkbox"/> Suit settled Out-of-Court   | <input type="checkbox"/> Awaiting mediation     |
| <input type="checkbox"/> Suit filed but dropped by claimant | a. Date claim paid: _____  | <input type="checkbox"/> Awaiting court action: |
| <input type="checkbox"/> Summary Judgment in our favor      | b. Amount paid: _____  | a. Reserve amount:                              |
|   | c. did you want to settle this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No | _____   |

- |  |  |
|--|--|
| <input type="checkbox"/> Court outcome in your favor | <input type="checkbox"/> Court outcome in favor of plaintiff |
| <input type="checkbox"/> Jury Verdict                | <input type="checkbox"/> Jury Verdict                        |
| <input type="checkbox"/> Directed Verdict            | <input type="checkbox"/> Directed Verdict                    |

9. Name and address of the attorney assigned to your case: \_\_\_\_\_

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? YES  NO  If "Yes", amount was \$ \_\_\_\_\_

Signature: \_\_\_\_\_

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

Name (Printed): \_\_\_\_\_