



Professional Liability/Medical Malpractice Preferred • Standard • Non-Standard

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WARNING - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

APPLICATION FOR NURSE ANESTHETISTS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

- 1. (a) (i) Full name of Applicant:
(ii) Professional Degree:
(b) Principal business address:
(c) (i) Phone: (ii) Fax:
(iii) E-Mail Address: (iv) Website Address:
(d) (i) Date of Birth (MM/DD/YYYY): (ii) Place of Birth:
2. (a) Requested Effective Date: (b) Requested Retroactive Date:
3. Are you a U.S. citizen?
4. (a) Type of practice for which coverage is requested:
(b) The practice for which coverage is requested is:
5. Do you own a locum tenens company?

6. Do you work for and/or accept work assignments or placements from any locum tenens company? Yes No
 If Yes, complete the following for each company:

<u>Name of Company</u>	<u>Address</u>	<u>Employee or Independent Contractor</u>	<u>No. of Hrs. Each Month</u>	<u>Is Prof. Liab. Insurance Provided to You? (Yes/No)*</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

* If Yes, attach a copy of your Certificate of Insurance.
 If No, are you requesting coverage for this activity?..... Yes No

7. Are you a free-lance locum tenens not placed by or associated with any locum tenens company?..... Yes No
 8. Are you currently in active military service?..... Yes No
 9. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

10. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... Yes No
 If Yes,
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No
 (ii) Provide the name and title of the Applicant's Privacy Officer. _____
 Our Business Associate Agreement is available by calling us at (502) 244-1056. This is the only Business Associate Agreement we will recognize.

II. EDUCATION AND TRAINING

1. Provide the following information:
- | | <u>Name of Institution</u> | <u>City</u> | <u>State</u> | <u>Date Completed</u> |
|-----------------|----------------------------|-------------|--------------|-----------------------|
| Nursing School | _____ | _____ | _____ | _____ |
| Graduate School | _____ | _____ | _____ | _____ |
2. Provide a detailed summary of where you have practiced your profession since completing your training: _____

3. Are you a member of any professional societies? Yes No
 If Yes, provide information regarding your membership(s). _____

III. SCOPE OF PRACTICE

1. (a) Principal practice location for which coverage is requested:
- | | |
|-----------------|---------------|
| _____ | _____ |
| (Practice Name) | (Street) |
| _____ | _____ |
| (City) | (State) (Zip) |
- (b) Provide the number of weekly hours for your principal practice location (exclude on-call hours). _____
 (c) Your principal practice location is a(n):
 Hospital Ambulatory Surgery Center Professional Office with Specialty
2. (a) Secondary practice location for which coverage is requested. (If none, check here)
- | | |
|-----------------|---------------|
| _____ | _____ |
| (Practice Name) | (Street) |
| _____ | _____ |
| (City) | (State) (Zip) |
- (b) Provide the number of weekly hours for your secondary practice location (exclude on-call hours). _____

