



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

303 Middletown Park Place • Suite F • Louisville, KY 40243
Nationwide 1 (800) 216-1056 • (502) 244-1056 • FAX (502) 254-1056
www.pbsinsurance.com • E-mail - pbs@pbsinsurance.com

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 SPECIFIED MEDICAL PROFESSIONS FOR PROFESSIONAL LIABILITY INSURANCE (Claims Made Basis) APPLICANT'S INSTRUCTIONS:

- 1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION. (PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full name of Applicant (include professional degree if applicant is an individual):

b. Principal business premise address: (Street) (County)

(City) (State) (Zip)

Please attach a list of additional office addresses.

c. Number of Employees: Full time Part time Seasonal Total

d. Business Phone: () Home Phone: ()

e. Date of Birth: Place of Birth:

Are you a U.S. citizen? [] Yes [] No. If No, your status, date of entry into USA:

f. Square feet of total office space (all locations):

g. Your practice:

- [] Solo practitioner (unincorporated) [] Professional corporation (for profit)
[] Solo practitioner (incorporated) [] Professional corporation (non-profit)
[] Partnership [] Employee of (Give name of employer)
[] Professional Association
[] Other (please describe)

h. Formal business, corporate or partnership name:

i. Please list the names of all partners or members of your professional association/corporation who provide professional services:

j. Please attach a copy of your letterhead.

k. 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 (502) 244-1056. This is the only Business Associate Agreement we will recognize.

2. EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

- (i) Where have you practiced your profession during the last ten years?
- In _____ From _____ To _____
- In _____ From _____ To _____
- In _____ From _____ To _____
- (ii) Have you ever failed any professional licensing or specialty organization examination? [] Yes [] No
If yes, please attach a detailed explanation including the dates and location.

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

- b. Please indicate your professional specialty (CHECK ONE):
- | | | |
|---|--|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Naprapath | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Counselor (Describe)
_____ | <input type="checkbox"/> Nurse, Licensed Practical | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Nurse, Registered | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Hearing Aid Fitter | <input type="checkbox"/> Nurses Registry | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Home Health Care Agcy. | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Inhalation Therapist | <input type="checkbox"/> Optician | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Visiting Nurse Assoc. |
| <input type="checkbox"/> Medical Personnel Pool | <input type="checkbox"/> Orthotist | <input type="checkbox"/> X-ray Technician |
| | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Other (Specify) _____ |

c. Please indicate the sources and amounts of actual and projected revenue:

<u>Source</u>	<u>Amount This Fiscal Year</u>	<u>Amount Next Fiscal Year</u>
(i) Charitable Contributions:	\$ _____	\$ _____
(ii) Government Funding:	\$ _____	\$ _____
(iii) Fee for Services:	\$ _____	\$ _____
(iv) Other: _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

d. Please provide the number of patient or client visits:

<u>Type of Visit</u>	<u>Number of Visits Last 12 Months</u>	<u>Number of Visits Next 12 Months</u>
Clinic	_____	_____
Laboratory	_____	_____
Other (specify) _____	_____	_____
TOTAL NUMBER OF VISITS	_____	_____

e. Please specify any professional societies or associations in which you are a member: _____

f. Are you associated with or do you work for a physician or surgeon?..... [] Yes [] No
If yes, please give the name and the specialty of the physician: _____

