XINSURANCE

8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-678-7342 • Fax 800-498-9880

PARAMEDIC PROFESSIONAL LIABILITY

1. General Information Proposed Effective Date: _____

Applicant is (check all that apply): ☐ Registered Nurse (RN), ☐ First Year Graduate Registered Nurse (RN),
☐ Licensed Practical Nurse (LPN), ☐ Licensed Vocational Nurse (LVN), ☐Aides ☐ Assistants
☐ Nurse Practitioner (NP) ☐ Clinical Nurse Specialist (CNS) (with prescriptive or medical diagnostic authority)
☐ CNS (without prescriptive or medical diagnostic authority) ☐ Other: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: ( )_____ Fax: ( )_____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

2. Business Information

Detailed description of business activities (specifically, and by location): _____

_____

How many years have you been in business? _____

Indicate how you operate (please check all that apply):

☐ An Individual (Full Name): _____

☐ A Solo Corporation – Name of Corporation: _____

Any dba's or trade names? If yes, please list: _____

☐ A Shareholder of a Medical Corporation – Name of Corporation and Names of other Shareholders: _____

_____

☐ A Partner in a Medical Partnership – Name of Partnership and Name(s) of Partner(s): _____

_____

☐ A Professional Association – Name of Professional and Names of Associates: _____

_____

☐ An Employer – Name of Employer (Please specify if employed by an Individual, Corporation, Partnership, IPA, HMO): _____

_____

☐ An Independent Contractor – Name of Individual, Corporation or Partnership with whom you contract: _____

_____

☐ Sharing office space and/or expenses only – Names of Associates: _____

_____

Are you practicing as part of any affiliation not noted in question 4? If yes, please explain: _____

_____

_____

Do you employ, contract with or supervise any other healthcare providers? ☐ Yes ☐ No

If yes, please explain: _____

Name of licensed physician with whom you collaborate. _____

If not, please indicate your referral relationships. _____

_____

_____

_____

Annual Payroll: $ _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? ☐ Yes ☐ No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: ( )_____

Fax: ( )_____ Years with Company: _____

Employee's Responsibilities: _____

Does your practice comply in every way with the rules, regulations, guidelines and standard as set forth by your State Regulatory Board? ☐ Yes ☐ No

If no, please explain in detail any non-compliance issues (attach additional pages if necessary to provide all details): _____

_____

_____

_____

3. Insurance History (REQUIRED- Attach a five year loss/claims history, including details.)

A. Who is your current insurance carrier (or your last if no current provider)? _____

_____

B. Have you been non-renewed or cancelled by another carrier? ☐ Yes ☐ No

If yes, list the carrier and explain when, why including all details (please provide an additional page if necessary): _____

C. Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$
Policy Limits			

D. Have you had any incident, event, occurrence, loss, or wrongful act which might give rise to a claim, lawsuit or loss? ☐ Yes ☐ No

If yes, please explain (provide an additional page if necessary): _____

E. Has the Applicant or anyone on the Applicant's behalf, attempted to place this risk in standard markets?

☐ Yes ☐ No

If the standard markets are declining placement, please explain which carriers and why: _____

F. If you carry malpractice insurance, please mark where coverage exists? ☐ Ground Medical Transport ☐ Rotor Wing Medical Transport ☐ Fixed Wing Medical Transport ☐ Hospital

G. Has any insurance carrier ever declined, surcharged, rated-up, restricted, cancelled or refused to renew your medical malpractice insurance? ☐ Yes ☐ No

If yes, please explain (provide an additional page if necessary): _____

H. Has the Applicant or any predecessor or related person or entity ever had a malpractice claim, suit or incident? ☐ Yes ☐ No

Desired Insurance

☐ **Limit of Liability (with per person sub-limit):**

- ☐ $25,000 per person / $50,000 per accident / $100,000 aggregate
- ☐ $50,000 per person / $100,000 per accident / $300,000 aggregate
- ☐ $100,000 per person / $250,000 per accident / $500,000 aggregate
- ☐ $250,000 per person / $500,000 per accident / $1,000,000 aggregate
- ☐ Other: _____

☐ **Limit of Liability (with no per person sub-limit):**

- ☐ $50,000 per accident / $100,000 aggregate
- ☐ $100,000 per accident / $300,000 aggregate
- ☐ $250,000 per accident / $500,000 aggregate

Self-Insured Retention (SIR): ☐ $1,000 (Minimum) ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ Other: _____

Note: Higher SIRs will generally reduce the premium charged, but SIRs of $2,500 or greater must be accompanied by proof of the Applicant's ability to pay that SIR amount (i.e. last year's tax return forms).

4. Business Activities

A. Professional Designation

☐ Neonatal/Pediatric Transport, ☐ Pre-Hospital Care, ☐ Community Health, ☐ Critical Care Transport,

☐ Critical Care/ICU ☐ Emergency Room, ☐ Hospital, ☐ Air Medical Transport, ☐ Maternal & Child,

☐ Ground Medical Transport ☐ Pediatric Transport, ☐ Other _____

_____

_____

B. Describe in detail the regular operations and services you provide: _____

_____

_____

_____

C. Estimated Number of patient visits per week: _____

D. Estimated Number of hours worked per week: _____

E. State Certification or License: Primary State_____ License No.: _____

Date Issued: _____ Expiration Date: _____ DEA Number: _____

NREMTP License No. _____ Expiration Date: _____

Other States Licensed: _____
List states, number and date

F. Person providing accounting and tax services:

a. Name: _____

b. Address: _____

G. Are you seeking:

a. Insurance to cover work performed exclusively by you? ☐ Yes ☐ No

b. Insurance to cover work done by others under your direction? ☐ Yes ☐ No

c. Insurance to cover the actions of individuals on your payroll? ☐ Yes ☐ No

H. Employee breakdown (if applicable)—please enter the number of:

	Full-Time	Part-Time
Operational Staff		
Non-Operational employees (drivers, collectors, supervisors, etc.)		

I. List all Hospitals (name and location) where you have or are applying for staff privileges. _____

_____

_____

_____

J. Have you ever applied for admitting privileges and been turned down? ☐ Yes ☐ No

K. REQUIRED- Attach a copy of your risk criteria.

L. Do you have transfer agreements with any hospitals? ☐ Yes ☐ No

If yes, please identify all in detail (attach additional pages if necessary to provide all details): _____

_____

_____

_____

M. Do you have a physician write orders? ☐ Yes ☐ No

N. Do you have prescriptive privileges? ☐ Yes ☐ No

O. Do you supervise students? ☐ Yes ☐ No

6. Medical Training/Education

Please include a current copy of your curriculum vitae (CV) and a copy of your practitioner/associate certificate.

Attaching a CV does not preclude the need to fully complete this application.

Institution/Program:

_____ _____
NAME OF INSTITUTION CITY/ STATE COUNTRY

_____ From: _____ To: _____
DEGREE /CERTIFICATION MONTH/YR MONTH/YR

Other:

_____ _____
NAME OF INSTITUTION CITY/ STATE COUNTRY

_____ From: _____ To: _____
DEGREE /CERTIFICATION MONTH/YR MONTH/YR

7. Work History

A. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.) **Please account for all time since training. Please explain any gaps in your education or profession practice history.**

Name of Employer	City	State	From: Mnth/Yr	To: Mnth/Yr

8. Additional Underwriting Information

If not applicable, please note with a N/A.

A. Have you ever been convicted of a crime (felony or misdemeanor)? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

B. Have you ever suffered from or been treated for substance abuse, mental illness or serious health or physical condition? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

C. Have you ever had a complaint filed against you with an State Regulatory Board? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

D. Have you ever had any professional license/permit or narcotics license investigated, suspended, revoked, restricted or placed on probation? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

E. Have you ever been warned about your performance or placed on any type of probation during your training? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

F. Do you elicit record and evaluate a health, psychosocial and developmental history of the patient? ☐ Yes ☐ No

G. Do you perform a physical examination? ☐ Yes ☐ No

H. Describe in detail the techniques and instrument used (attach additional pages if necessary to provide all details): _____

I. Do you order or perform appropriate diagnostic tests? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

J. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referral and consolation when appropriate? ☐ Yes ☐ No

Please provide details to your response (attach additional pages if necessary to provide all details): _____

K. Do you have any medical-related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

L. Do you provide weight loss treatment or diet therapy? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

M. Do you provide healthcare services to correctional facilities? ☐ Yes ☐ No

If yes, please provide details (attach additional pages if necessary to provide all details): _____

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer’s accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant’s facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name