MEDICAL PROFESSIONALS LIABILITY QUESTIONNAIRE

NOTE: THIS COVERAGE IS INTENDED TO BE EXCESS COVERAGE OVER OTHER PROFESSIONAL LIABILITY POLICIES.

Please answer all questions. Submit this questionnaire with a completed ACORD application and prior carrier loss runs.

Named Insured: ____________________________________________

Website: ____________________________________________

Requested Effective Date: ____________________ Expiration Date: ____________________

ELIGIBLE PROFESSIONAL DESCRIPTIONS

Audiologist □ Dietary Technician □
Corrective Therapist □ Dental Assistant □
Dental Hygienist □ Dialysis Technician □
Day Care Center Nurse □ Medical Record Technician □
Dietician □ Nurse Aide □
EEG Technician □ Nurse Assistant □
EKG Technician □ Occupational Therapist/ Massage Therapist □

PROFESSIONAL PERSONAL MEDICAL PAYMENTS PREMIUMS

Each Each Each Each Each Each Each
Person Occurrence Aggregate Person Aggregate Each Each Annual
Policy Pd Policy Pd Policy Pd

$1,000,000 $1,000,000 $1,000,000 $100,000 $100,000 $1,000 $10,000 $160.00
500,000 500,000 500,000 100,000 100,000 1,000 10,000 150.00
300,000 300,000 300,000 100,000 100,000 1,000 10,000 75.00
100,000 100,000 100,000 100,000 1,000 10,000 65.00

STUDENT APPLICANT

$100,000 $100,000 $100,000 $100,000 $100,000 $1,000 $10,000 $50.00
50,000 50,000 50,000 50,000 50,000 1,000 10,000 45.00

If Applicant is a student, state the date or expected date of graduation and/or accreditation. ____ / ____ / ____

PROHIBITED CIRCUMSTANCES

If any of the questions in this section are answered “YES,” you are not eligible for coverage.

1. Is the location of employment in private homes? ☐ Yes ☐ No

2. Are there past or pending professional malpractice or personal liability claims against you? ☐ Yes ☐ No

If any of the questions in this section are answered “NO,” you are not eligible for coverage.

3. Are you working under written or standing doctor’s orders? ☐ Yes ☐ No

GENERAL INFORMATION
1. State your professional license or registration number assigned by state and/or other regulatory body? __________

2. Description of professional duties: ____________________________________________________________

3. Location of employment:
   - Clinic
   - Dental Office
   - Doctor’s Office
   - Hospital
   - Nursing Home
   - *Other _____
   - *Submit for eligib

4. Do you supervise any other nurses or health care professionals? □ Yes □ No
   If “YES”, describe: ____________________________________________________________

5. Are you a proprietor or officer of any medical establishment? □ Yes □ No
   If “YES”, describe: ____________________________________________________________

6. Has any insurer during the past three years cancelled your coverage? □ Yes □ No
   Submit to UW if “YES”
   If “YES”, describe: ____________________________________________________________

**IMPORTANT NOTICE**

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

Applicant Signature __________________________ Title __________________________ Date __________

Producer Signature __________________________ Date __________

**PLEASE ENCLOSE TOTAL PAYMENT AND MAIL TO THE AGENT SHOWN ABOVE.**