Nevada Mutual Insurance Company

Professional Liability Coverage Ancillary Provider Application

With your completed application, you must submit the following information:

1. Current declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made, and you are not applying for prior acts coverage.
3. Current business letterhead.
4. Current Curriculum Vitae
5. Copy of your approved notification of supervision form.
6. Copy of current professional liability insurance declarations page.
7. Claims history.
8. Copies of your practice protocols.

Nevada Mutual Insurance Company

Nevada Mutual Insurance Company
709 SHADOW LANE, LAS VEGAS, NV 89106 PH: (702) – 798 – 6001 FAX: (952) – 974 - 2240

PROFESSIONAL LIABILITY COVERAGE
ANCILLARY PROVIDER APPLICATION

REQUESTED EFFECTIVE DATE	RETROACTIVE DATE?	SOCIAL SEC. #	D.O.B

NAME_____ e-mail address_____
Last First MI

HOME ADDRESS_____
Street City State Zip

CURRENT EMPLOYER_____
Name Telephone Number

BUSINESS ADDRESS _____
Street City State Zip

1. Profession:
   - ☐Physician's Assistant
   - ☐Surgeon's Assistant
   - ☐Psychologist
   - ☐Certified Nurse Midwife
   - ☐Podiatrist
   - ☐Optometrist
   - ☐Paramedic/EMT
   - ☐Other (Describe) _____
   - ☐Certified Nurse Practitioner
   - ☐Certified Registered Nurse Anesthetist
   - ☐Emergency Medical Technician

2. Is your employer insured by Nevada Mutual Insurance Company? ☐ **Yes** ☐ **No**

3. Have you ever:
   - A. been convicted of a criminal offense? ☐ **Yes** ☐ **No**
   - B. been treated for (or recommended for treatment) for alcoholism, sexual, or drug addiction? ☐ **Yes** ☐ **No**
   - C. undergone psychiatric treatment? ☐ **Yes** ☐ **No**
   - D. had a complaint filed against you with any hospital or regulatory board? ☐ **Yes** ☐ **No**
   - E. had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? ☐ **Yes** ☐ **No**

If the answer to any part or parts of 3, above, is "Yes," please provide complete details on a separate sheet of paper.

4. Do you moonlight (work outside control of employer)? If "Yes," where? ☐ **Yes** ☐ **No**

_____

_____

5. Do you hold the certification or licensure required in your state to practice your profession? ☐ **Yes** ☐ **No**
   If "Yes," where did you receive your training?

_____

6. Are you a member of any professional organization? If "Yes," please give details. ☐ **Yes** ☐ **No**

_____

_____

7. Have any judgments ever been rendered against you or any out-of-court settlements in excess of $500 been made on your behalf from an incident alleging professional errors or omissions? ☐ **Yes** ☐ **No**

   If "Yes," give details on a separate sheet. If available, please enclose copy of the complaint.

8. Has any action been filed against you or have you been notified that any action, regardless of dollar amount will be filed against you alleging professional errors or omissions? If "yes," give details on a separate sheet. If available, please enclose copy of complaint. ☐ **Yes** ☐ **No**

9. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, or refused to renew your insurance?
If yes, please give details on a separate sheet. ☐ **Yes** ☐ **No**

10. Will you be scheduled to work at a separate location from your supervising physician? If "Yes," please give details on a separate sheet. ☐ **Yes** ☐ **No**

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

12. Do you order or perform diagnostic tests? ☐ **Yes** ☐ **No**

13. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referrals and consultations when needed? ☐ **Yes** ☐ **No**

14. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? ☐ **Yes** ☐ **No**

15. Do you perform a physical examination? If “Yes”, briefly describe techniques and instruments used: ☐ **Yes** ☐ **No**

_____

_____

16. Do you conduct informed consent discussions? ☐ **Yes** ☐ **No**

17. Describe any other procedures, treatments, or duties you perform:

_____

_____

18. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice.

_____

_____

19. Please list all states in which you are licensed along with each license number and renewal date:

STATE	LICENSE #	RENEWAL DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

IMPORTANT! YOU MUST READ CAREFULLY

SPECIFIC CONSENT
TO CONDITIONS OF CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application - regardless of whether or not I am granted insurance - and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

_____ _____

Applicant's Signature **Date**

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following page of this Application is an *Authorization To Release Information* form which requires your signature. Please read carefully.

If you are to be added to an existing NMIC as an employee the following must be completed:

INSURED PHYSICIAN OR ENTITY AUTHORIZATION

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

REQUESTED EFFECTIVE DATE: _____ SHARED LIMITS COVERAGE ☐

SEPARATE LIMITS COVERAGE ☐

Signature of Supervising Physician/Entity Officer: _____Date _____

Please print name: _____

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by Nevada Mutual (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical and professional associations and medical and professional societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for the State of Nevada and any other State in which he has practiced, or resided, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

_____

Date: _____

ADDITIONAL COMMENTS