Nevada Mutual Insurance Company"

Medical Professional Liability Residents Insurance Application Form

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.

Nevada Mutual Insurance Company

Requested Effective Date:______________________
MONTH DAY YEAR

Requested Retroactive Date:______________________ (if not the same as effective date explain)
MONTH DAY YEAR

Coverage will become effective upon the completion of all underwriting functions and acceptance by the Company.

NOTE: If any space provided herein is insufficient for complete reply, please use Page 4, and/or a separate sheet, identifying by number the questions you answer.

1. PERSONAL INFORMATION

A. Full Name of Applicant:______________________
FIRST MIDDLE LAST

B. Date of Birth:______________________ C. Place of Birth:______________________
MONTH DAY YEAR

D. Social Security Number:______________________

E. Home Address: ______________________

____

____
CITY STATE ZIP

F. Home Telephone:______________________ G. e-mail Address: ______________________

2. LICENSING INFORMATION. LIST ALL STATES IN WHICH YOU ARE LICENSED TO PRACTICE MEDICINE

STATE	LICENSE NUMBER	DATE ISSUED	MEMBER OF STATE MEDICAL ASSOCIATION?
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐

3. EDUCATIONAL INFORMATION

MEDICAL SCHOOL DATA			
NAME OF MEDICAL SCHOOL(S) ATTENDED	LOCATION OF MEDICAL SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates: YES ☐ NO ☐

Identify all past and current Residencies, Internships, etc.

RESIDENCIES, INTERNSHIPS, FELLOWSHIPS, PRECEPTORSHIPS					
HOSPITAL DATA			DATES (MONTH/YEAR)		COMPLETED?
NAME	LOCATION	DEPARTMENT	START	END	
					YES NO*
					YES NO*
					YES NO*
					YES NO*
					YES NO*
					YES NO*
					YES NO*

* IF “NO” CHECKED, EXPLAIN FULLY ON PAGE 4 AND/OR A SEPARATE SHEET

FOR YOUR PROTECTION THE FOLLOWING WARNING IS REQUIRED BY VARIOUS STATE LAWS: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or person , files an application for insurance or 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, and may be subject to a civil and/or criminal penalties.

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 University's insurance program is not a right of every licensed medical doctor who makes application for insurance, 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.

ADDITIONAL COMMENTS