



Agency:
Address:

Phone/email:

ALLIED EMPLOYEE APPLICATION

Name (First, Middle Initial, Last) Designation

Employer or Group Name

Office Address (Include City, State, Zip)

Business Phone:	Mobile Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Business Fax:	E-mail Address:	Date of Birth:
Home Phone:	Contact Name::	Social Security No:

PROFESSIONAL EDUCATION

School of Graduation	City	State	Country	Year Completed
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Do you practice as:

- | | | |
|--|--|---|
| <input type="checkbox"/> Graduate Nurse
<input type="checkbox"/> Optician
<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Licensed Practical Nurse
<input type="checkbox"/> Optometrist
<input type="checkbox"/> Student Nurse
<input type="checkbox"/> Nurse Anesthetist | <input type="checkbox"/> Pharmacist
<input type="checkbox"/> X-Ray Therapist
<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> Physicians Assistant
_____ Specialty
<input type="checkbox"/> Nurse Surgical Assistant
<input type="checkbox"/> Licensed Counselor | <input type="checkbox"/> Psychiatric Nurse
<input type="checkbox"/> Social Worker
<input type="checkbox"/> Clinical Nurse Specialist
<input type="checkbox"/> Psychologist
<input type="checkbox"/> Nurse Midwife
<input type="checkbox"/> other _____ |
|--|--|---|

LICENSURE

States in which you hold a license. Indicate what percentage of your total practice is spent in each.

State	License Number	Date of License	% of Total Practice

1. Has your medical license in any state ever been suspended, revoked or restricted? Yes No
2. Are you currently under investigation by any state licensing board or agency? Yes No
3. Has your federal or state registration to prescribe controlled medications ever been refused, suspended, revoked or limited? Yes No
4. Will you be performing activities which will be covered by another professional liability policy?
If yes, indicate who will provide this coverage and what professional services it will cover. Yes No
5. Have you ever suffered from or been treated for any substance abuse, disability, mental illness or serious physical injury or illness that has or might affect your ability to practice medicine or surgery?
If yes, state the illness or disability and the date it occurred below. Yes No

6. Have you ever been arrested for, charged with or convicted of a crime other than a minor traffic violation? Yes No
If yes, provide details below.
7. Do you treat inmates? Yes No
If yes, provide the number of hours per week: _____
8. Do you teach, supervise or proctor medical students, residents or fellows? Yes No
If yes, provide the number of hours per week: _____
9. Do you participate in clinical trials for any pharmaceutical or for any organization acting on behalf of a pharmaceutical? Yes No
If yes, describe below.
10. Do you own, operate or serve as an executive, administrative officer, medical director or department head for any hospital, nursing home, non-hospital surgical center, urgent care clinic, commercial laboratory, government agency or other facility or organization? Yes No
If yes, indicate its name and describe your duties below.
11. Do you hold any positions outside of your principal medical or surgical practice (e.g., working in a hospital emergency room or part time at a clinic or nursing home, working for an HMO or other managed care or insurance company, serving as a Medical Director, etc.)? Yes No
If yes, indicate for whom you provide these services below.
12. Has any hospital ever taken action to deny, suspend, revoke or restrict your medical staff privileges on your application or reapplication for medical staff privileges? Yes No
If yes, explain below and provide pertinent documentation.
13. Have you ever resigned from a hospital staff while under investigation or to avoid possible disciplinary action? Yes No
If yes, explain below and provide pertinent documentation.
14. Do you provide services over the internet? Yes No
15. Do you perform any procedure not typical to the specialty in which you received your license? Yes No
If yes, describe those activities below.
16. Do you administer Botox injections in any non-clinical settings? Yes No

**Question
Number**

Fully explain any yes answers and provide supporting documentation:

COVERAGE HISTORY

SUBMIT A COPY OF YOUR MOST RECENT POLICY DECLARATIONS

List your previous professional liability insurers for the last **10 years**, begin with most recent insurer.

Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date
Insurer	Limits of Coverage	Policy Period	Occurrence <input type="checkbox"/>	Claims-Made <input type="checkbox"/>	Retroactive Date

1. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement (Tail coverage)? If yes, provide proof of coverage. Yes No
2. Has your application for professional liability insurance ever been declined, or has your policy premium ever been surcharged, canceled or nonrenewed by the insurer? Yes No
If yes, explain below.
3. Has your professional liability coverage always been continuously in force? Yes No

Question

Number Fully explain any yes answers to questions 1 and 2 and provide supporting documentation

CLAIMS HISTORY

1. In the past ten years, has any malpractice claim or suit been made against you? Yes No
 If yes, how many? _____
2. Do you have knowledge of any incident, adverse outcome or other circumstances that might reasonably lead to such a claim or suit? Yes No
 If yes, how many? _____ Have all of them been reported to your previous insurers? Yes No

Complete a Claims Supplement Form for each claim, suit or potential claim.

ATTACH LOSS RUN FROM ALL INSURERS LISTED UNDER THE COVERAGE HISTORY SECTION

ALLIED EMPLOYEE COVERAGE SELECTION

Desired coverage effective date: _____ 12:01 a.m.

Desired coverage type:

- CLAIMS-MADE **With Prior Acts Coverage.** Retroactive date used by your existing carrier: _____ 12:01 a.m.
- CLAIMS-MADE Complete prior acts application.
- CLAIMS-MADE-PLUS **Without Prior Acts Coverage** (decline or do not need retroactive coverage). The retroactive date on the policy applied for will be the same as the effective date of coverage.
- Includes extended reporting endorsement (tail coverage).**

Describe the practice for which you need insurance:	PRACTICE HOURS PER WEEK	
	Average hours (not just patient contact)	
	Patient visits (in office, hospital, etc.)	
	Surgeries (major in hospital)	
	Obstetrical deliveries	

Locations where you practice. List principal location first. Total percentage of practice at all locations should equal 100%.

PRACTICE LOCATIONS

1. _____
 Address City State Zip Code % of Practice
2. _____
 Address City State Zip Code % of Practice
3. _____
 Address City State Zip Code % of Practice

HOSPITAL LOCATIONS

1. _____
 Hospital Name City State County Privilege Type % of Practice
2. _____
 Hospital Name City State County Privilege Type % of Practice
3. _____
 Hospital Name City State County Privilege Type % of Practice

Locations (other than present) where you have practiced since completion of formal training (include military or public service organizations):

Practice Name and Location	From	To

PRACTICE ORGANIZATION

Check the boxes that best describe your practice affiliation(s):

Employment Status

- Employee
- Shareholder/Partner***
- Solo Unincorporated***
- Solo Corporation***
- Independent Contractor for

Entity Type

- Professional Corporation
- Business Corporation
- Limited Liability Corporation
- Partnership
- Professional Association
- Joint Venture
- Other

***Entity application must be completed.**

Corporation, Partnership or Employer Name: _____

REMARKS. Use the space below for any comments that you feel will help HPIX better understand your practice.

CERTIFICATION AUTHORIZATION AND SIGNATURE

CONDITIONS OF MEMBERSHIP

There are several conditions to the undersigned's membership and continued membership with HPIX. Failure to comply with any of these conditions is grounds for non-renewal of the undersigned's membership and insurance policy. These conditions include, but are not limited to, that the undersigned hereby agrees to:

- (1) Accept and cooperate with coordinated defense to the extent ethically permissible.
- (2) Participate in and cooperate with programs that promote intensive risk management whenever requested by HPIX or its attorney-in-fact. Whenever requested by HPIX or its attorney-in-fact, the undersigned hereby agrees to undergo, at the undersigned's expense, and cooperate with a practice audit by an independent third party selected by HPIX or its attorney-in-fact to review various administrative and clinical patterns of practice.
- (3) Report incidents at the time they become known to the undersigned.

The undersigned agrees to fully comply with HPIX 's conditions of membership, including those listed above, and agrees that the undersigned's membership in HPIX and insurance policy may be non-renewed by HPIX if the undersigned fails to comply.

The undersigned certifies that the information in this application is true and correct and authorizes the release and exchange of any information regarding the undersigned's medical training, claim or credit history, hospital privileges, professional status or other matters related to this insurance by and between any hospital, medical school, insurance company, agent or broker, licensing or regulatory agency or authority or any professional association, society or specialty board of which the undersigned is or has been a member and HPIX.

The undersigned further agrees to indemnify and hold harmless from any liability or expense any person or organization providing information in good faith, pursuant to this authorization.

NOTICE TO NEW JERSEY APPLICANTS:

Any person who knowingly and with intent to defraud any insurance company or other 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 subjects such person to criminal and civil penalties.

Applicant's signature: _____ Date: _____