



**Medical
Assurance**

**ALLIED HEALTH
PROFESSIONAL LIABILITY
APPLICATION**

Medical Assurance, Inc.
8425 Woodfield Crossing Blvd., Suite 300
Indianapolis, IN 46240
(317-469-4100 or (800) 284-7424



OGREN INSURANCE
Jack Ogren & Co., Inc.

6929 Hohman Avenue • Hammond, IN 46324-1496
Phone 219-933-0076 • Fax 219-933-0080

Application is hereby made for insurance in the amount indicated below. The declarations contained herein are made as representations on which the policy is to be issued.

COVERAGE LIMITS
\$250,000 each claim/\$750,000 annual aggregate

Requested Effective Date: _____ / _____ / _____
 Mo. Day Yr.

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

Section I - Personal Information:

1. Full Name of Applicant: _____ Sex _____ Social Security #: _____
 Last First MI M/F

2. Date of Birth: _____ U.S. Citizen _____ DEA #: (if applicable) _____
 () Yes () No - Explain
 Mo Day Year

3. Primary Business Address: _____	Mailing Address: _____
Address _____	Address _____
County _____	County _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
() _____	() _____
Telephone Number _____	Telephone Number _____

4. Profession: _____ License Number: _____

() Physician's Assistant	() Perfusionist	() Nurse Practitioner
() Nurse Anesthetist	() Registered Nurse	() Counselor
() Surgeon's Assistant	() Licensed Practical Nurse	() Other _____
() Psychologist	() Optometrist	(Specify)
() Nurse Midwife	() Emergency Medical Technician	

Section II - Continuing Education & Training:

5. Type of Certification/Licenses you currently hold: _____

6. List states in which you actively practice: _____

7. Education: (Please list most recent attendance first)

<u>Institution</u>	<u>Dates of Attendance</u>		<u>Date Graduated</u>	<u>Certification or Degree Received</u>
	<u>Mo/Yr</u>	<u>Mo/Yr</u>		
a. _____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____
c. _____	_____	_____	_____	_____

8. List continuing education courses and credits received within the last 2 years: (or attach copies of certificates and/or credits received)

9. Has your Certification/License in any state ever been (voluntarily or otherwise) suspended, denied, revoked, restricted or limited in any way?
() No () Yes - explain:

10. List where practiced: (most recent location first)

a.	_____	_____	_____
	Location	Dates	Reason for Leaving
b.	_____	_____	_____
	Location	Dates	Reason for Leaving
c.	_____	_____	_____
	Location	Dates	Reason for Leaving
d.	_____	_____	_____
	Location	Dates	Reason for Leaving
e.	_____	_____	_____
	Location	Dates	Reason for Leaving

Section III - Current Practice:

11. Describe briefly your general duties: _____

12. Describe the extent to which you are supervised and by whom: _____

13. List all present employers and indicate applicable response:

	Employer	# of Hours	Employee	Independent Contractor
1.	_____	_____	()	()
2.	_____	_____	()	()
3.	_____	_____	()	()

14. Does your employment require work in an Emergency Room? () No () Yes - Explain: _____

Section IV - Insurance History:

15. Have you ever been insured by Mutual Assurance or Medical Assurance for professional liability?

() No () Yes - List Policy Number or name of previous employer: _____

16. If professional liability coverage is provided through your employer, do you maintain a separate policy for professional liability? () No () Yes. If so, please provide a copy of your declarations page. A Certificate of Insurance may also be required.

17. Have you ever been diagnosed with or professionally advised to seek treatment for alcohol/drug abuse or addiction, mental illness or chronic physical illness?

() No () Yes - Explain: _____

18. Have any fee or professional relation complaints been registered against you with your professional association(s), hospital(s) or any state licensing authority?

() No () Yes - Explain: _____

19. Have you ever been charged with or convicted of a criminal offense?

() No () Yes - Explain: _____

20. Has your professional liability insurance ever been canceled, suspended, non-renewed, declined or issued only on special terms?

() No () Yes - Explain: _____

21. Has any claim, suit or arbitration proceeding for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim, suit or arbitration proceeding?

() No () Yes - Complete the following. If you need more space, attach an additional sheet.

Patients Name	Date of Occurrence
Insurance Carrier	Dates of Treatment
Allegations	
<hr/> <hr/> <hr/> <hr/>	
Additional Defendants	
<input type="checkbox"/> Claim has been closed or settled Amount paid or reserved If claim is closed, date <input type="checkbox"/> Claim is still open and pending \$ closed or settled	

22. Prior Professional Liability Insurance Carriers:

Name of Company	Policy Limits	Period of Coverage	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence
Name of Company	Policy Limits	Period of Coverage	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence

This application is the basis for coverage; therefore, any incorrect or incomplete statements or answers could nullify coverage. Completion of this form neither binds coverage nor guarantees that a policy will be issued.

I hereby request that my application for insurance coverage be submitted for consideration to Mutual Assurance and its affiliates. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to Mutual Assurance and its affiliates any and all information requested which may relate to my insurability.

I hereby warrant and represent that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my protection.

I hereby consent to the review by Mutual Assurance and its affiliates of any incidents or occurrences likely to result in malpractice allegation or claim. I agree to cooperate in the review of claims and incidents which apply to the coverage requested.

Where applicable, I hereby consent to the review of my application by the committees appointed by my county or state professional association/society. I agree to cooperate with these committees.

Signature in Full

Date

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.