APPLICATION FOR DESIGNATED EMPLOYEE COVERAGE TO BE COMPLETED BY NURSE ANESTHETIST/ANESTHESIOLOGIST ASSISTANT

(All statements below must be completed and all questions answered completely)

DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER LETTER HAS BEEN RECEIVED.

1. Name ____________________ Phone No. (_____) ____________
2. Name of Employer ______________________________
3. Mailing Address ______________________________
   (Address of Employer)
4. I request an effective date of 12:01 A.M. ________________, 20 __________
5. ARNP-Nurse Anesthetist/Anesthesiologist Assistant License No. ______________
   Date Issued______________________________
6. Date employed __________ Birth date __________ Birth place __________

6a. Employed As: ☐ Independent Contractor, ☐ W-2 Employee, Other ______________

7. EDUCATION
   (a) RN Training:
   ____
   Name of Hospital City & State Dates: From To

   (b) Anesthesia Training:
   ____
   Where What Type Dates: From To

   (b) Additional Training:
   ____
   Where What Type Dates: From To

8. What is the name of your current professional liability insurer, policy number and expiration date?
   ____
   (If Independent Contractor, please include a copy of your current declarations page)
9. Have you ever been involved in a malpractice claim or suit either directly or indirectly? __________
   (**Complete supplementary claims information form for each claim or suit.)**
10. Have you ever had Professional Liability Insurance refused, declined, cancelled or accepted on special terms? __________ If **Yes**, give details: ______________________
11. PREVIOUS WORK EXPERIENCE
    Employer Address Dates Employed
    ____
    ____
12. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

______________ Date

______________________________ Signature of Nurse Anesthetist/Anesthesiologist Assistant

______________ Date

______________________________ Signature of Employer

FPIC-28 (3/06)

SUPPLEMENTARY CLAIMS INFORMATION

Please use separate form for each claim, if there has been more than one claim.

IMPORTANT: The word "claim" as used in question #10 refers to:

1. Any suit or claim, settled or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate or employee, or
2. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you.

Complete information is necessary to avoid possible complications under your insurance policy issued in reliance upon this application.

PATIENT'S NAME ______________________________

ADDRESS ______________________________

DATE OF INCIDENT AND YOUR TREATMENT ______________________________

____

____

ALLEGATIONS ______________________________

____

PRESENT STATUS OF CLAIM: (check applicable answer)

☐ 1. Suit threatened, no action taken

☐ 2. Dropped by claimant

☐ 3. Awaiting court action

☐ 4. Summary judgment in your favor

☐ 5. Court trial in your favor

☐ 6. Out of court settlement in the amount of $______________

☐ 7. Court settlement in the amount of $__________________

☐ 8. Waiting for mediation

AT THE TIME OF CLAIM, YOUR INSURANCE COMPANY WAS ______________________________

POLICY NUMBER ________________________

ATTORNEY WHO REPRESENTED YOU AND HIS ADDRESS ______________________________

____

THE ABOVE IS A TRUE AND CORRECT STATEMENT AND BY SIGNING THIS FORM, I HEREBY AUTHORIZE MY PRIOR INSURANCE COMPANY TO RELEASE ANY CLAIM INFORMATION REQUESTED BY ANESTHESIOLOGISTS' PROFESSIONL ASSURANCE COMPANY (APAC).

Date ________________________ Signature ________________________

(A photostatic copy of this authorization shall be considered as effective and valid as the original.)