Roush Insurance Services, Inc.

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- ☐ **Deerfield Insurance Company**
- ☐ **Evanston Insurance Company**
- ☐ **Essex Insurance Company**
- ☐ **Markel American Insurance Company**
- ☐ **Markel Insurance Company**
- ☐ **Associated International Insurance Company**

APPLICATION FOR ANESTHESIOLOGIST ASSISTANTS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: _____

   (ii) Professional Degree: _____

   (b) Principal business address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) (i) Phone: _____ (ii) Fax: _____

   (iii) E-Mail Address: _____ (iv) Website Address: _____

   (d) (i) Date of Birth (MM/DD/YYYY): _____ (ii) Place of Birth: _____

2. (a) Requested Effective Date: _____ (b) Requested Retroactive Date: _____

3. Are you a U.S. citizen? ..... [ ] Yes [ ] No
   If No, what is your status in the U.S. and current citizenship? _____

4. Are you currently in active military service? ..... [ ] Yes [ ] No

5. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No

   (i) If no, has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No

   (ii) If yes, provide the name and title of the Applicant's Privacy Officer: _____

   Our Business Associate Agreement is available at https://www.markelcorp.com/en/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

II. EDUCATION AND TRAINING

1. Provide the following information:

	Name of Institution	City/State	Date Completed
AA Accredited Training School			

Unaccredited School or Distance Learning? ..... [ ] Yes [ ] No

	Certification Date	Re-Certification Date
NCCAA Certification		

2. (a) First time in practice? ..... [ ] Yes [ ] No

(b) If no, provide a details where you have practiced for past six years:

Name of Facility	City/State	From (MM/YYYY)	To (MM/YYYY)

3. (a) Are you a member of American Society of Anesthesiologists (ASA)? ..... [ ] Yes [ ] No
   (b) Are you certified in ____ PALS or ____ ACLF? (check one) ..... [ ] Yes [ ] No
   (c) Other? _____

III. SCOPE OF PRACTICE

1. (a) Type of practice for which coverage is requested
   (i) Solo Practitioner (incorporated) ..... [ ] Yes [ ] No
   If yes, Name of Entity: _____
   Address: _____
   Type of Practice: ____ Hospital ____ Surgery Center ____ Other _____ (check one)
   Additional Locations as Solo Practitioner for which coverage is requested. (If none, check here [ ])
   _____
   Do you employ anyone? ..... [ ] Yes [ ] No
   If Yes, please indicate by profession, the number of individuals you employ:
   _____ AA _____ CRNA _____ MD/DO _____ Other
   Do you wish to include coverage for employees? ..... [ ] Yes [ ] No
   If Yes, please provide an application for any CRNA or MD employee.
   If Yes, are all employees licensed in accordance with applicable state and federal regulations? ..... [ ] Yes [ ] No
   If no, what limits are employees required to carry? _____
   Is entity a locum tenens company? ..... [ ] Yes [ ] No
   If Yes, are you requesting coverage for this company? ..... [ ] Yes [ ] No
   If Yes, please complete our Locum Tenens and Contract Staffing Application (Form # MALT 5000)
   (ii) Employee or Independent Contractor ..... [ ] Yes [ ] No
   If yes, do you work solely for one Anesthesiologist and/or an Anesthesiologist Group? ..... [ ] Yes [ ] No
   If yes, do you work for a locum tenens or contract staffing company? ..... [ ] Yes [ ] No
   If yes, do you work for ____ Hospital or ____ Surgery Center (check one) ..... [ ] Yes [ ] No
   Name of Entity: _____
   Address: _____
   Type of Practice: ___ Hospital _____ Surgery Center _____ Other _____ (check one)
   Additional Locations for which coverage is requested as employee or IC. (If none, check here [ ])
   _____
   _____
   (iii) Free-Lance, working in multiple locations ..... [ ] Yes [ ] No
   If yes, Name of Entity: _____
   Address: _____
   Type of Practice: ____ Hospital ____ Surgery Center ____ Other _____ (check one)

Name of Entity: _____

Address: _____

Type of Practice: ____ Hospital ____ Surgery Center ____ Other _____ (check one)

Name of Entity: _____

Address: _____

Type of Practice: ____ Hospital ____ Surgery Center ____ Other _____ (check one)

(iv) Employee of Department of Veteran Affairs or Department of Defense under TRICARE program? ..... [ ] Yes [ ] No

If yes, please provide details: _____

_____

(v) Other ..... [ ] Yes [ ] No

If yes, please provide details: _____

(b) The practice for which coverage is requested is:

(i) Full-time: ..... [ ] Yes [ ] No

If Yes, provide the number of weekly hours (exclude on-call hours) _____

If Yes, provide average number of patients you saw during the last 12 months _____

If Yes, provide estimated number of patients you will see during the next 12 months _____

(ii) ___ Part-time or ___ moonlighting (check one) (for which coverage is requested): ..... [ ] Yes [ ] No

If Yes, provide the number of weekly hours for all jobs combined for which coverage is requested _____

If Yes, provide the average number of patients you saw during the last 12 months combined _____

If Yes, provide estimated number of patients you will see during the next 12 months combined _____

If Yes, will need the following (for which coverage is not requested for):

1. Name and address of your full-time position and number of weekly hours not including on-call.

   _____

2. Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice.

(iii) Annual gross revenue for which coverage is requested for: _____

2. (a) Provide the following information for all of the states you are licensed, in which you practice:

State	License No.	Effective Date	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(b) If working in physician delegated state, please advise what states you will be working in _____

(i) Does your practice comply in every way with the rules and regulations as set forth by your State Board of Medicine? ..... [ ] Yes [ ] No

3. Are you 100% supervised by an Anesthesiologist at all locations for which coverage is requested? ..... [ ] Yes [ ] No

4. Indicate the approximate percentages of your patients for which coverage is requested:

___% Bariatric Surgery ___% Dental/Oral Surgery ___% Obstetrical ___% Ophthalmological

___% Pediatric ___% Podiatric ___% Plastic or Other Cosmetic Surgery

___% Non-Surgical Pain Management (describe) _____

___% Research or Experimental (describe) _____

___% Other Surgery or Experimental (describe) _____

5. During administration of all anesthetics, is a pulse oximeter monitor continuously used? ..... [ ] Yes [ ] No

If No, explain. _____

6. During all anesthetics:
   (a) Is an electrocardiogram continuously displayed? ..... [ ] Yes [ ] No
   If No, explain. _____
   (b) How often is arterial blood pressure determined and evaluated? _____
   (c) How often is heart rate determined and evaluated? _____
   (d) How is circulatory function evaluated? _____
7. During all general anesthesia, is an end tidal CO2 monitor used continuously?..... [ ] Yes [ ] No
   If No, explain. _____
8. For all general anesthesia, does Anesthesiologist/Care Team:
   (a) Use an oxygen analyzer with a low concentration limit alarm? ..... [ ] Yes [ ] No
   If No, explain. _____
   (b) Test proper functioning of alarms prior to each use?..... [ ] Yes [ ] No
   If No, explain. _____
9. When ventilation is controlled by a mechanical ventilator, does Anesthesiologist/Care Team:
   (a) Use a device equipped with a full set of safety alarms?..... [ ] Yes [ ] No
   If No, explain. _____
   (b) Test proper functioning of alarms prior to each use?..... [ ] Yes [ ] No
   If No, explain. _____
10. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? ..... [ ] Yes [ ] No
    If No, explain. _____
11. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date*

    * Attach a copy of the Declarations page from your current policy.
12. Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism?.... [ ] Yes [ ] No
    If Yes, identify. _____
13. Do you anticipate any changes in your practice or location in the next year?..... [ ] Yes [ ] No
    If Yes, attach a detailed explanation.

IV. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? ..... [ ] Yes [ ] No
   If Yes, how many? _____Complete a copy of our Supplemental Claim form for each one.
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? ..... [ ] Yes [ ] No
   If Yes, how many? _____Complete a copy of our Supplemental Claim form for each one.

3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?..... [ ] Yes [ ] No

   If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.

4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by an employer, contractor, hospital, managed care organization or other organization to deny, limit, suspend, non-renew or revoke your privileges, employment or ability to practice? ..... [ ] Yes [ ] No

   If Yes, attach complete copies of all official documents issued by the organization which address the allegations, the findings, and the outcome.

5. Has your license to practice or your NCCAA Certification ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? ..... [ ] Yes [ ] No

   If Yes, attach complete copies of all documents issued by the licensing authorities involved in each investigation, restriction, suspension, revocation, probation or termination.

6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct?..... [ ] Yes [ ] No

   If Yes, attach complete copies of all documents issued by the licensing authorities involved in each investigation.

7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? ..... [ ] Yes [ ] No

   If Yes, attach a detailed summary of the circumstances, charges, jurisdiction, dates and current status/outcome of each, and complete copies of any documents issued by police or judicial authorities which confirm your current status or outcome.

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? ..... [ ] Yes [ ] No

   If Yes, attach a detailed summary of your diagnosis, treatment dates and locations, treating physicians, current status and copies of any licensing board or hospital documents related to your status.

9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? ..... [ ] Yes [ ] No

   If Yes, attach a detailed summary of your status.

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant _____ Title _____

Signature of Applicant _____ Date _____

Agency _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

Notice to 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 the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS