Employed Healthcare Extender Professional Liability Application for Claims Made Coverage

OCEANUS INSURANCE COMPANY
A Risk Retention Group

I. – APPLICANT INFORMATION

Employer's Name & Address:	
Name of Employee:	
License # / State Certification:	School/Training/Certification & Year of Completion:

II. – APPLICANT PRACTICE INFORMATION

Medical Specialty:	☐ Physician Assistant	☐ Advanced Practice Registered Nurse
	☐ Physician Assistant (Surgical)	☐ Certified Registered Nurse Anesthetist
	☐ Nurse Practitioner	☐ Other: _____

Are you providing services outside your scope of duties for the employer listed above? If "Yes" please provide a description.	☐ Yes ☐ No

III. – COVERAGE REQUESTED

Effective Date:		Retroactive Date:
Limits of Liability:	☐ Shared Limits ☐ Separate Limits	Each Claim $_____ Annual Aggregate $_____

IV. – APPLICANT PRACTICE HISTORY

Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, voluntarily surrendered or subject to probationary terms?	☐ Yes ☐ No
Do you now or have you ever had a chronic physical limitation or any mental or emotional illness or disorder which impaired or could adversely affect your practice of medicine to any degree?	☐ Yes ☐ No
Have you ever had a complaint or claim brought against you for sexual misconduct?	☐ Yes ☐ No
Have you ever been indicted and/or convicted of a crime other than a minor traffic violation?	☐ Yes ☐ No
Do you or have you ever had a drug or alcohol addiction or dependency or sought treatment for such?	☐ Yes ☐ No
Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?	☐ Yes ☐ No

V. - PLEASE REVIEW AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company.
I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other firm, or professional association.
I understand and agree that any material misrepresentation or omission by me in this application may act to void such insurance and may give the Company a right to rescind such coverage.
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_____ _____
Signature of Applicant Date

This coverage is issued by a risk retention group. This risk retention group may not be subject to all insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for this risk retention group.