COPIC
Better Medicine • Better Lives

This is a claims-made policy. Please review your policy provisions carefully to understand and determine all of your rights and duties.

NEW ALLIED HEALTH EMPLOYEE AND INDEPENDENT CONTRACTOR APPLICATION

Only NEW employees or independent contractors not previously reported to COPIC need to complete this application.

EMPLOYER/PHYSICIAN INFORMATION:

1. Employer Name ____________________
2. Address ____________________ City __________ State ___ Zip __________
3. Phone # ____________________ Fax # ____________________

EMPLOYEE INFORMATION:

4. Employee/Independent Contractor Name ____________________
   Requested Effective Date:____/____/______
5. SS#:_____ - _____ - ________ NPI# ____________________ Birth Date:____/____/______
6. Please identify below all physician practices for which you provide professional services and for which you are requesting COPIC coverage, your primary job function at each, whether you are an employee or an independent contractor and the average number of hours per week that you work at each:

Practice Name	Primary Job Function	Employee	Independent Contractor	Hours
____________	____________	❑	❑	Average # hours/week*_____
____________	____________	❑	❑	Average # hours/week*_____
____________	____________	❑	❑	Average # hours/week*_____
____________	____________	❑	❑	Average # hours/week*_____

**When indicating the total number of hours worked per week, please estimate all office time including patient contact, charting time, consultations, etc.; all operating time and emergency room time; all on-call time which results in actual patient contact; and all time spent making hospital rounds.*

Please complete and attach to this application a separate Agreement (page 7) for each COPIC-insured physician employer/supervisor.

7. Legal Residence (Physical Street/Home Address) ____________________
   ____________________ City __________ State_____ Zip __________
8. Rural Mailing Address/P.O. Box, if applicable:
   P.O. Box __________ City __________ State _____ Zip __________
9. Home Phone # __________ Home Fax # __________ Cell Phone # __________
10. Personal/confidential e-mail address ____________________ Business e-mail address ____________________

11. Education/School Name: ______________________________ State:________

Degree/Position (Please include your C.V.): ______________________________

12. Job Description: ______________________________

____

MEDICAL LICENSE INFORMATION:

13. **License, Certification or Registration:** **License #:** **State:** **Date From:** **Date To:**

License, Certification or Registration	License #	State	Date From	Date To

14. DEA License Number ______________________________ From ___________ To ___________

15. Certification(s) held ______________________________ From ___________ To ___________

Certification(s) held ______________________________ From ___________ To ___________

16. **PROCEDURE INFORMATION – Do you perform:**

Botox Injections	❑ Yes ❑ No	Laser Hair Removal	❑ Yes ❑ No
Chemical Peels	❑ Yes ❑ No	Micro-Dermabrasion	❑ Yes ❑ No
Collagen Injections	❑ Yes ❑ No	Micro-Pigmentation	❑ Yes ❑ No
Endermology	❑ Yes ❑ No		

Other, please describe: ______________________________

If you answered "yes" to any of the above procedures, you must include a copy of your documentation of training with this application.

17. Do you manage the active labor and deliver Vaginal Birth after Caesarean (VBAC) patients without a responsible physician being physically on premises and immediately available for the entire course of care?.. ❑ Yes ❑ No ❑ N/A

18. List **all** entities to receive certificates of insurance (e.g., hospitals, HMOs, IPAs, etc.)

Name	Address (including city, state and zip code)

By adding a certificate holder's name and address to the above list, you give COPIC permission to allow the certificate holder to obtain your certificate of insurance.

19. Have you been out of the practice of medicine for longer than 6 months prior to the requested effective date listed on this application? ❑ Yes ❑ No

    If "yes," please provide copies of CMEs or other activities (formal or informal) obtained during this time.

A "yes" answer to questions 20-29 requires an explanation on practice letterhead.

20. Has any professional liability insurer ever canceled, declined to issue, refused to renew, offered renewal with a surcharged rate or required that you accept a deductible, or issued coverage with any restrictions or exclusions? ❑ Yes ❑ No
21. Has any disciplinary action ever been taken regarding any professional license, permit or narcotics license which you hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. (Disciplinary actions include, but are not limited to, suspension, revocation, probation, practice limitations, reprimand, letter of admonition, censure and any allegations which are currently pending.) ❑ Yes ❑ No
22. Have you ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a guilty plea, entered a plea of nolo contendere or been placed on adult diversion for any violation of any law? **Note**: You must answer "yes" even if the charges(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do not involve alcohol or drugs. ❑ Yes ❑ No
23. Have you ever been warned, reprimanded, or censured by a medical staff, hospital, health care facility, or any other health care entity? ❑ Yes ❑ No
24. Have you incurred or suffered any chronic illness or physical injury in the past 24 months OR are you currently a registrant in any state's medical marijuana registry? ❑ Yes ❑ No
25. Have you ever had staff privileges at a hospital limited, reduced, restricted, denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action or potential disciplinary action? ❑ Yes ❑ No
26. Have you ever had any person complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Nursing, health plan, managed care organization or other medical review committee? ❑ Yes ❑ No
27. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? ❑ Yes ❑ No
28. Have you ever been accused of sexual misconduct or harassment by an employee of a hospital or surgery center; or have you been accused by a patient of or been investigated by any state regulatory authority in connection with boundary violations of a sexual nature? ❑ Yes ❑ No
29. Have you ever been reported to the National Practitioners Data Bank? ❑ Yes ❑ No

30. Do you provide any medical or consultative services for which you are requesting COPIC coverage outside of your principal state of practice or do you have plans to do so in the next 12 months? ❑ Yes ❑ No

    If "yes," please indicate the state(s) or foreign country(ies) in which these services are to be rendered: ________

    ____

    And the number of hours per week you will devote in each state or foreign country: ________________________

    ____

31. Do you or will you perform office-based surgery utilizing conscious sedation, regional or general anesthesia? ❑ Yes ❑ No

    If "yes," are you aware of and do you abide by the guidelines, if any, established by the appropriate regulatory body in your principal state of practice (such as a medical licensing board, board of medical examiners, board of nursing, etc.)? ❑ Yes ❑ No

ALLIED HEALTH CLAIMS INFORMATION

Important information regarding questions 32 through 34 (including sub-questions):

1. The word “claim” as used in Questions 32 through 34 refers to:
   a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
   b. 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 or any partner, associate, employee or professional corporation or partnership.
2. If you answer “yes” to question 32 through 34 (including sub-questions), please complete the attached Supplementary Claims Information Form (page 5).

32. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? .... ❑ Yes ❑ No

33. Please indicate if you are aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit:

   a. A request for records from a patient and/or attorney related to an adverse outcome? .... ❑ Yes ❑ No

   b. A letter from an attorney regarding your medical treatment of a patient? .... ❑ Yes ❑ No

   c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, or other significant disabilities? .... ❑ Yes ❑ No

   d. Patient or family member dissatisfaction with the outcome of a procedure, treatment, or diagnosis? .... ❑ Yes ❑ No

   e. Any other circumstances that might reasonably lead to a claim or suit? .... ❑ Yes ❑ No

34. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier?.. ❑ Yes ❑ No ❑ N/A*

   **For purposes of this question, “N/A” means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

   If “no,” please explain:____

ALLIED HEALTH SUPPLEMENTARY CLAIMS INFORMATION FORM

If there has been more than one claim, please photocopy this form. Attach additional sheets if needed.
All questions must be answered or marked Not Applicable (N/A).

1. Patient's name: ____
2. Date reported to insurance company: ______________________________
3. Name of insurance company: ____________________________________
4. Date of incident and your treatment: ______________________________
5. Allegations: ____

   ____

   ____

6. What is the present condition of the patient? _________________________

   ____

   ____

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? .... ❑ Yes ❑ No
8. Status of claim (check applicable answer):

❑ Suit threatened, no action taken ❑ Suit filed but dropped by claimant ❑ Summary judgment in your favor	Court outcome in your favor: ❑ Yes ❑ No	❑ Awaiting mediation ❑ Awaiting court action
❑ Suit settled out of court a. Date claim paid:___________ b. Amount paid: $ ___________ c. Did you want to settle this claim? ❑ Yes ❑ No	Court outcome in favor of plaintiff: Amt. of Loss Payment: $ ___________________	Reserve Amount: $ ________________

9. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ❑ Yes ❑ No

   If "yes," amount was $ _________________

Employee/Independent Contractor Signature _____________________________ **Date**___________

Please PRINT your name ____

I understand that the information submitted herein becomes part of my professional liability insurance application as submitted.

Employer/Administrator Signature ___________________________________ **Date**___________

ALLIED HEALTH PROFESSIONAL AGREEMENT

By signing below, you acknowledge that:

1. You will **not** have professional liability (malpractice) insurance with COPIC for any work outside the scope of your employment by or affiliation with the person(s) or entity(ies) designated in the practices section of this application.
2. You will **not** have an individual limit of liability. You will **share** in the limit of liability with your employer or contracting physician depending upon the policy structure of your employer or contracting physician.
3. If your immediate prior policy was a claims-made policy, you must ensure that you purchase or are provided extended reporting coverage (tail coverage) from your former insurer. Alternatively, you may submit a written request to us for prior acts coverage. Such a request will be subject to underwriting review and approval. Failure to take one of these two steps may result in a gap in your insurance coverage.
4. COPIC does **not** provide "tail" coverage to allied health professionals. As long as your employer or contracting physician purchases "tail" coverage at the time of termination of their coverage with COPIC, you will be provided coverage in the future for unknown claims that may have occurred during the period of time you provided such medical services. If your employer or contracting physician does not purchase "tail" coverage at the termination of their coverage with COPIC, you will not be provided coverage for any unknown future claims. You may wish to request from your employer or contracting physician a written confirmation that "tail" coverage will be purchased at the time of termination of their coverage with COPIC.

Employee/Independent Contractor Signature ________________________________ **Date** ____________

Please PRINT your name ____

Physician Signature ____ **Date** ____________

Please PRINT your name ____

* *

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.

ALLIED HEALTH UNDERSTANDING, AUTHORIZATION, & RELEASE OF INFORMATION

I understand that this is an application for insurance and not an insurance binder! I understand and agree that as a condition of being insured, I accept the requirement to submit to a health and skills assessment by a physician of COPIC's choice. This assessment may be required at COPIC's discretion.

I hereby declare and warrant that all answers and statements herein given are true and complete to the best of my knowledge and that no material fact or circumstance concerning the subject matter of this application has been omitted or withheld. I understand that these answers and statements are material and as such will be relied upon in the determination by the company to grant my liability insurance. If I or any other person making application or providing information on my behalf misstate or fail to disclose any pertinent information, my application may be declined. If my application is approved and it includes any misstatement or failure to disclose pertinent information, COPIC has the right to cancel my insurance. COPIC also has the right to decline coverage for a specific claim if COPIC would have declined to issue insurance or limited my coverage if I had not made the misstatement or omission.

Further, I recognize and agree that as a prerequisite to acceptance of this application and consideration for granting of liability insurance, COPIC and/or its assigns may conduct a peer review investigation of me and/or my practice. As part of such peer review investigation, I consent to the release of any prior Practice Quality Report and to periodic chart and medical record reviews conducted by Practice Quality, as COPIC may request or direct. I agree to abide by any recommendations arising from that review. For Colorado and Nebraska insureds only: I understand and will comply with the guidelines of COPIC's Participatory Risk Management Program (available from the practice administrator/office manager).

I authorize any state board of medical examiners, state board of nursing or licensure, hospital board or committee, hospital records department, insurance company, professional society, past or present, business or medical associate or private person that may have any record or knowledge concerning any of the answers or statements made herein to release such information to COPIC or its assigns. I authorize the use of a copy of this authorization in lieu of its original.

As may be permitted by law and in compliance with COPIC policy, I hereby consent to COPIC's release of the following information about me to credentials verification organizations, health plans, hospitals, health care organizations, professional liability insurance carriers, and state and federal regulatory entities, including but not limited to boards of medical examiners, the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank and to the fullest extent permitted by law, hereby release all providers of such information, including COPIC, its employees and agents, from any and all liability therefore. This release applies to the following information: my name, business address, social security number, NPI number, license number, hospital affiliations, policy numbers, effective dates, limits of liability, retroactive date, specialty, PLI rate class, and any information concerning those claims which are required to be reported to any state board of medical examiners or medical licensing body or authority, National Practitioner Data Bank and/or the Healthcare Integrity and Protection Data Bank.

Applicant's signature____ Date ____________________

Please PRINT your name ____

WE SUGGEST YOU RETAIN A COMPLETED COPY OF THIS APPLICATION FOR YOUR RECORDS

Please check this application to ensure that you have answered all questions and included all requested attachments. Submitting an incomplete application could result in a delay in underwriting and processing or an outright rejection of your application.