



Please mail the completed and signed application with supporting documentation to:

Yellowstone Insurance Exchange, RRG  
 Attn: Eric J. Gardzina, CPHRM  
 4301 Hillsboro Pike, Suite 310  
 Nashville, Tennessee 37215  
 Tel. 866-216-7433  
 Fax 866-216-7434

**APPLICATION FOR ALLIED HEALTHCARE INDIVIDUAL (CLAIMS MADE)**

**Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.**

PLEASE TYPE OR PRINT LEGIBLY

**Personal Information**

**Requested Coverage Effective Date:** \_\_\_\_\_ **Requested Retroactive Date** \_\_\_\_\_

1. Full Name of Applicant \_\_\_\_\_
2. Applicant's Date and Place of Birth Date \_\_\_\_\_ Place of Birth \_\_\_\_\_
3. Home Address (Street, City, State, and Zip Code) \_\_\_\_\_
4. Principle Business Address (Street, City, State, and Zip Code) \_\_\_\_\_  
 E-mail \_\_\_\_\_
5. County \_\_\_\_\_
6. Principle Correspondence Address \_\_\_\_\_
7. Social Security No. \_\_\_\_\_
8. Business Phone \_\_\_\_\_
9. Home Phone \_\_\_\_\_
10. Your Profession \_\_\_\_\_
11. Licensed/Certified by \_\_\_\_\_ No. \_\_\_\_\_
12. **Name of Hospital where you are or will be employed** \_\_\_\_\_

- a. Are you going to be an employee of a hospital?  Yes  No
- b. Date of Employment \_\_\_\_\_
- c. What department? \_\_\_\_\_ How many hours a week will you be on duty? \_\_\_\_\_

## Education and Training

13. Indicate your educational background (attach a copy of your Curriculum Vitae)

	Location	Degree	Date
a. School			
b. Other			
c. Post Graduate			
d. Add'l Degrees or Training			

14. To what professional association(s) do you belong?

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## Previous Professional Experience

Employers Name	Employers Address	Start Date	End Date

## Insurance Information

15. Please list your professional liability policies for the past three years

Company	Policy Limits	Deductible	Retro Date					Policy Period
				Claims Made		Occurrence		
				Claims Made		Occurrence		
				Claims Made		Occurrence		

**If at any time you were without insurance, please indicate on a separate sheet of paper.**

16. Did you purchase an Extended Reporting Endorsement (tail coverage)?  Yes  No

17. Are you employed by, or are you an independent contractor for physicians or dentists?  Yes  No

If yes, list all physician and dentist names, where they are insured, limits of liability, and policy expiration dates.

Name	Insurer	Limits	Policy Expiration

18. Have you ever: **(explain any yes answers on a separate sheet of paper)** Yes No
- a. Have you ever been diagnosed/treated for alcoholism, narcotics addiction or mental illness?
  - b. Have you ever been convicted of any civil or criminal act by any State or Federal authority?
  - c. Have you ever had a complaint filed against you by any State Board of Medicine?
  - d. Have you ever had any State medical license or certification revoked, restricted, limited, denied, suspended, subject to probationary conditions, voluntarily relinquished or otherwise sanctioned?
  - e. Have you ever had your defined hospital staff or similar privileges refused, modified, suspended or voluntarily surrendered?
  - f. Have you ever had your membership in a professional society refused, modified, suspended or revoked?
  - g. Have you ever had a claim or been sued for medical professional liability?(Please submit information on the attached Supplemental Claims Informational form. Make additional copies of the form if needed.)
  - h. Have you ever had professional liability insurance refused, cancelled or non-renewed?
  - i. Have you ever been diagnosed as having tested positive for Hepatitis B?
  - j. Have you tested for the antibody?
  - k. Have you ever been diagnosed as having or tested positive for HIV or Acquired Immunodeficiency Syndrome?
- Yes No
19. Do you assist in Surgery?
20. Do you administer anesthesia?
- Are you supervised?
- Are you unsupervised?
21. Do you perform normal deliveries?
22. Do you have any other specialized training?  
If yes, give details: \_\_\_\_\_
23. Have you changed your field or scope of practice or modified your specialty during the past three years?  
 Yes  No  
If yes, explain: \_\_\_\_\_
24. Have you changed the address of your practice during the past three years?  Yes  No  
If yes, list prior address: \_\_\_\_\_
25. Do you know of any incidents, facts, circumstances, acts, errors or omissions which could reasonably be expected to become the basis of a claim or suit against you for professional liability  Yes  No  
If yes, please provide details on a separate sheet of paper.

**Applicant must sign at bottom of pages 4, 5 and 6**

**Notice: Failure to provide complete and accurate information regarding actual claims, suits, incidents, acts, errors, or omissions which could reasonably be expected to become the basis of a claim or suit will result in no coverage under the policy.**

Signing this application does not bind **Yellowstone Insurance Exchange, RRG** to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information, or attempt to defraud or attempt to defraud or lie to **Yellowstone Insurance Exchange, RRG** about any matter contained in this application, then coverage provided by virtue of this application is void.

Date: \_\_\_\_\_

(X) \_\_\_\_\_  
(Applicant)

(X) \_\_\_\_\_  
(Witness)

# Yellowstone Insurance Exchange, RRG

## AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, have provided *Yellowstone Insurance Exchange, RRG* information in their insurance application in order for *Yellowstone Insurance Exchange, RRG* to evaluate my insurability under their policy of insurance.

Therefore, I hereby authorize all persons, firms, corporations, including, but not limited to, prior liability carriers, hospitals and their officers, directors, medical staff, and employees, medical association, medical society, the State Board of Medical Examiners for any state in which I have practiced and any other entity, either public or private, to provide *Yellowstone Insurance Exchange, RRG* with any information, whether written or otherwise, which may be material to evaluating my application for insurance with *Yellowstone Insurance Exchange, RRG*. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to *Yellowstone Insurance Exchange, RRG*.

I consent for *Yellowstone Insurance Exchange, RRG* to use photocopies of this "Authorization for Release of Information" to present to those persons or entities supplying information as provided herein. Each photocopy is to be considered an original copy.

Date: \_\_\_\_\_ (X) \_\_\_\_\_  
(Applicant)  
(X) \_\_\_\_\_  
(Witness)

### Additional Required Information: Please include with application

- CV
- Copy of State License
- Copies of all certificates, to include DEA, ACLS, PALS, ATLS.
- Loss Runs/Claims Histories from each carrier for every employer during the last 5 consecutive years. (Please include copies of Certificates of Insurance as well.)
- Three (3) written professional references.

# Yellowstone Insurance Exchange, RRG

## *SUPPLEMENTAL CLAIM INFORMATION*

### **INSTRUCTIONS TO THE APPLICANT**

As indicated on Question 18g of the **Yellowstone Insurance Exchange, RRG** Allied Healthcare Provider Professional Liability Application the following information is required. Please complete a separate form for each claim or suit reported:

1. Name, age and sex of patient: \_\_\_\_\_  
\_\_\_\_\_
2. Date of first consultation: \_\_\_\_\_  
\_\_\_\_\_
3. Physical condition and diagnosis at above date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Dates of treatment given and nature of same: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Date of claim, and allegations made against you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Disposition of claim, amount of judgment or settlement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. What insurance company, if any was involved? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Subsequent condition or health of patient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Names of others, doctors, if any, involved in the claim or suit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. To whom may we refer for further information about the suite? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby understand that information submitted herein becomes a part of and is incorporated with my Professional Liability Application and is subject to the same conditions.

Date: \_\_\_\_\_

(X) \_\_\_\_\_  
(Applicant)

(X) \_\_\_\_\_  
(Witness)