

**NON-PHYSICIAN HEALTH CARE PROVIDER  
PROFESSIONAL LIABILITY INSURANCE APPLICATION**



You are applying for coverage under *Conventus'* claims-made policy. If your application is accepted by *Conventus*, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to *Conventus* either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

**900 Route 9 North, Suite 503, Woodbridge, New Jersey 07095**

**Phone: (877) 444-0484**

**Fax: (732) 791-9431**

**[www.conventusnj.com](http://www.conventusnj.com)**

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PROFESSIONAL LIABILITY INSURANCE APPLICATION**

**Section I – General Information (All questions must be completed. If no or none, so state.)**

1. Name and address of applicant

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact person \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

E-Mail \_\_\_\_\_

2. Broker name and address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

3. Birth Date \_\_\_\_\_

4. Social Security Number \_\_\_\_\_

5. List all locations where you work.

Employer	Street	City	County	State	Zip	Specialty	# hrs per mo	Phone

6. Requested policy period from: \_\_\_\_\_ to: \_\_\_\_\_

7. Requested retroactive date \_\_\_\_\_

8. Limits of liability if separate policy is desired:

\$1,000,000/\$3,000,000       \$2,000,000/\$4,000,000       Other \_\_\_\_\_

9. Do you practice as:

<input type="checkbox"/> Graduate Nurse	<input type="checkbox"/> Optician	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Optometrist	<input type="checkbox"/> Student nurse
<input type="checkbox"/> Nurse Anesthetist	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> X-Ray Therapist
<input type="checkbox"/> Nurse midwife – deliveries	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> First Nurse Surgical Assistant
<input type="checkbox"/> Nurse midwife – no deliveries	<input type="checkbox"/> Physician’s Assistant	<input type="checkbox"/> Dental Assistant/Hygienist
<input type="checkbox"/> Nurse Practitioner	(with surgical assisting?)	<input type="checkbox"/> Licensed Counselor
Specialty _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Clinical Nurse Specialist	<input type="checkbox"/> Psychiatric Nurse	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Other (describe) _____		

*Please attach a copy of all licenses and/or certifications.*

10. Type of practice (Check all that apply)
- Employed Provider                       Sole Proprietor/Unincorporated     Limited Liability Corporation
- Professional Association               Independent Contractor               Principal in a Professional Corporation
- Partnership                                   Other (describe) \_\_\_\_\_

11. List all states in which you are or have ever been licensed or certified.

State	License #	Certificate #	Current Yes/No

**Please explain, in detail, any “Yes” answers**

12. Has your professional license ever been denied, suspended, revoked or Voluntarily surrendered or has probation been invoked?  Yes               No
- 

13. Are you currently aware of any investigation being conducted which could impact your license?  Yes               No
- 

14. School of graduation \_\_\_\_\_ Degree \_\_\_\_\_ Date \_\_\_\_\_

15. Provide detailed description of your principal activity while working.

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16. Do you provide any service over the Internet or through a telemedicine program?  Yes               No

17. Percentage of practice by state.

State	% of patients	% of hospital	% of office hours

18. Has your employment ever been terminated?  Yes               No
- 

19. Are you currently being, or have you ever been, treated for alcoholism or substance abuse?  Yes               No
-

20. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation or partnership to which you belong or have belonged?  Yes  No  
 If yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage?  Yes  No

**Please provide completed details for each incident on the Supplemental Claims Information Form and attach to this application. The name of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amount or current status must be included.**

21. Do you have knowledge of any claims, potential claims, circumstances that could possibly result in claims, or suits in which you, your employees, or any professional association, corporation or partnership to which you belong or have belonged, may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim?  Yes  No  
 If yes, has this incident (these incidents) been reported to a prior insurer?  Yes  No

**Please provide completed details for each incident on the Supplemental Claims Information Form and attach to this application. The name of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amount or current status must be included.**

22. Name of current professional liability insurance carrier. \_\_\_\_\_

Policy Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Type of Coverage:  Occurrence  Claims-Made

If Claims-Made, was tail coverage purchased?  Yes  No

23. Has any company ever cancelled, not renewed or refused coverage?  Yes  No

24. Do you follow all state laws, federal laws and specific national association protocols?  Yes  No

If "No", please explain and attach a copy of the protocols followed:

**Section II – Signature**

**This section must be completed by all applicants.**

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind *Conventus* to complete the insurance, but it is agreed that this application shall be the basis of a contract should a policy be issued. I authorize the release and exchange of any underwriting or claims information between all prior carriers and *Conventus*.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

I understand that *Conventus* reserves the right to reject any applicant that does not meet its underwriting standards.

**Notice to New Jersey 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 such person to criminal and civil penalties.