UMIA

310 East 4500 South, Suite 600
Salt Lake City, Utah 84107-3993
t. 801.531.0375 • 800.748.4380 • **f.** 801.531.0381

APPLICATION FOR ANCILLARY PERSONNEL PROFESSIONAL LIABILITY INSURANCE AS ADDITIONAL NAMED INSURED

PLEASE TYPE OR PRINT RESPONSES AND ANSWER ALL QUESTIONS. COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETE.

COVERAGE REQUESTED TO COMMENCE 12:01 AM ON _____ (MO/DAY/YR)

Named Insured:_____ **Policy Number** _____
(For UMIA use only)

1. NAME AND ADDRESS OF ADDITIONAL NAMED INSURED

First | Middle | Last | Title

Home Address | City/State | Zip | Home Phone

Date of Birth | State/Lic. Number/Type | Soc. Sec. #

2. EMPLOYMENT INFORMATION

Location of Employment

☐ Doctors Office ☐ Hospital ☐ Clinic ☐ Home

☐ Dental Office ☐ Other Please specify: _____

Number of hours worked per week:_____

3. TYPE OF PROFESSION

☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Physician Assistant ☐ Nurse Practitioner

☐ LPN ☐ Registered Nurse ☐ Surgical Nurse ☐ Pump Perfusionist

☐ Lab Technician ☐ Dental Tech ☐ Other Please specify:_____

COVERAGE IS RESTRICTED TO SERVICES PERFORMED UNDER THE EMPLOYMENT AND UNDER THE DIRECT SUPERVISION OF THE NAMED INSURED.

4. CERTIFICATION INFORMATION

The applicant graduated from:_____

State any degree or certification involving your occupation:_____

State any special licenses or certificates required by any federal, state or local municipality:_____

Has the applicant ever:

Been subject to a disciplinary or investigative proceeding or reprimanded by a governmental or administrative agency, hospital or professional association?	☐ Yes	☐ No
Had any mental illness?	☐ Yes	☐ No
Had any chronic illness or physical defect?	☐ Yes	☐ No
Abused alcohol or drugs?	☐ Yes	☐ No
Been convicted of any misdemeanor or felony (other than minor traffic violations)?	☐ Yes	☐ No
Had restrictions on his/her license?	☐ Yes	☐ No

5. PRACTICE INFORMATION

Does the applicant render professional services directly to patients? ☐ Yes ☐ No

Describe these services:_____

Does the applicant perform or assist in surgery? ☐ Yes ☐ No

Does the applicant prescribe or dispense any drugs with the counter-signature of a physician? ☐ Yes ☐ No

Is the applicant employed or under contract with any other individuals or entity other than the named insured? ☐ Yes ☐ No

Please list:_____

6. INSURANCE INFORMATION

Has the applicant ever been canceled or declined coverage for malpractice insurance? ☐ Yes ☐ No

Are you aware of any circumstances which may result in any suit or malpractice claim being made or brought against the applicant? ☐ Yes ☐ No

Give details:

Please indicate name and policy number of prior or current carrier:

_____

Name Policy Number

☐ Occurrence ☐ Claims-Made Retroactive Date:_____

Reporting Form Endorsement ("Tail") purchased? ☐ Yes ☐ No

PLEASE NOTE:

No coverage for prior acts will be provided unless approved by UMIA.

When an employed ancillary person is named as an Additional Named Insured on the policy of the individual physician, the individual physician shares his/her limit of liability with the employed ancillary person. In the event a claim is made against both the individual physician and the employed ancillary person arising from the same loss, the limit of liability is the same as though a claim had been made against the individual physician only.

I certify that the foregoing information is true and correct and I authorize release and exchange of information involving either underwriting or claims matters between all prior insurance carriers and the UMIA. I further authorize UMIA to obtain a copy of my hospital privileges if not enclosed, secure reports directly from hospitals involving situations with potential liability, and obtain information regarding disciplinary procedures by specialty societies and the state licensing board.

I certify that I know of no claims, suits or occurrences presently pending which have not been reported to my previous carrier. The limit of liability provided will be a shared limit with the Named Insured. No additional limits apply.

_____

Signature - Additional Named Insured Date