UMIA

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

INDIVIDUAL APPLICATION FOR ANCILLARY PERSONNEL

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)

1. NAME AND ADDRESS

First	Middle	Last	Title
Home Address	City/State	Zip	Home Phone
Date of Birth	State/Lic. Number/Type	Soc. Sec. #	BNDD/(DEA#)

2. 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:_____

3. 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:_____

4. EMPLOYMENT INFORMATION
(Location of Employment)

☐ Doctors Office ☐ Hospital ☐ Clinic

☐ Dental Office ☐ Other Please specify:_____

Employed by:_____

IMPORTANT

COVERAGE IS RESTRICTED TO SERVICES PERFORMED WHILE EMPLOYED AND UNDER THE DIRECT SUPERVISION OF A UTAH MEDICAL INSURANCE ASSOCIATION INSURED PHYSICIAN OR CLINIC.

5. PRACTICE INFORMATION

Do you render professional services directly to patients? ☐ Yes ☐ No

Describe these services:_____

Do you perform or assist in surgery? ☐ Yes ☐ No

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

Are you employed or under contract with any other individuals or entity other than the insured physician or clinic? ☐ Yes ☐ No

Please list:_____

Are you entering private practice for the first time? ☐ Yes ☐ No

Number of hours per week involved in direct patient care:_____

Please list all office locations for which you are requesting coverage. List principal location first.

Number	Street	Suite	City	State	Zip	Phone
Number	Street	Suite	City	State	Zip	Phone
Number	Street	Suite	City	State	Zip	Phone

6. Please answer the following questions. If any are answered "Yes," please attach complete details on a separate sheet.

Have you 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 your license? ☐ Yes ☐ No

7. PROFESSIONAL LIABILITY COVERAGE

Limits of Liability desired: (Limits indicated are Each Loss Limit and Aggregate Limit)

☐ $100,000/$300,000 ☐ $500,000/$1.5 Mil ☐ $1 Mil/$3 Mil ☐ $2 Mil/$4 Mil
☐ $3 Mil/$5 Mil ☐ $4 Mil/$6 Mil ☐ $5 Mil/$7 Mil

8. BILLING MODE DESIRED

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

(Only monthly billing mode carries an interest charge)

9. INSURANCE INFORMATION

Have you 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

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

Name Policy Number

☐ Occurrence ☐ Claims-Made Retroactive Date:_____

Are you making application for Prior Acts coverage? ☐ Yes ☐ No

PROFESSIONAL PREMISES LIABILITY COVERAGE--Office based ancillary personnel will be required to purchase Professional Premises Liability Insurance. If purchased through UMIA, Limits are equal to the Professional Liability Limits selected up to $1 million/$3 million. In addition, property damage of $50,000 each occurrence and premises medical payments of $1,000 per person up to a maximum of $3,000 per year, and $25,000 each accident are included. UMIA does not underwrite coverage for office contents or personal property.

10. CLAIM INFORMATION:

Please TYPE all claim information. Failure to provide complete information as requested will result in delays in processing your application for insurance. If an incident was reported by you but no claim was made or suit filed, it is not necessary to provide information. **ALL SUCH INFORMATION SUPPLIED WILL BE TREATED IN A CONFIDENTIAL MANNER.**

a. Have you been involved in a claim or suit in the past ten years? ☐ YES ☐ NO

If "Yes," please provide a narrative description of the medical facts of each such claim or suit on a separate sheet. This narrative must include, but not be limited to, the following:

1. Age and sex of patient/claimant.
2. Date(s) and type(s) of treatment and/or surgery which led to the allegations against you.
3. Nature of allegations in claim or suit.
4. Specify whether a suit was ever filed.
5. Names of other health care providers and hospital, if any, involved in claim or suit.
6. Disposition or current status of suit:

☐ Open ☐ Closed If closed, was payment made? ☐ YES ☐ NO

If payment was made from your policy, state amount: $_____

If additional defendant was involved, state amount: $_____

If suit occurred within the last five years, please document the above with complete copies of hospital and office records.

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 of 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.

Name/Signature Date

IN THE EVENT YOUR POLICY IS CANCELED, EITHER BY YOU OR UMIA, YOU WILL HAVE THE RIGHT TO PURCHASE THE EXTENDED REPORTING FORM ENDORSEMENT "TAIL" COVERAGE. THIS ENDORSEMENT EXTENDS THE PERIOD FOR REPORTING OF CLAIMS ARISING FROM MEDICAL INCIDENTS WHICH OCCUR SUBSEQUENT TO YOUR POLICY'S RETROACTIVE DATE, AND PRIOR TO IT'S CANCELLATION DATE. YOU MUST EXERCISE THIS RIGHT WITHIN SIXTY DAYS FOLLOWING CANCELLATION, BY FULL PAYMENT OF THE PREMIUM.