INSPIRIEN

PO Box 211359
Montgomery, Alabama 36121-1359
334-271-5515

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR ALLIED HEALTHCARE PROVIDERS (CLAIMS MADE - INDIVIDUALS)

Personal Information

Requested Coverage Effective Date:_____ **Requested Retro Date**_____
Limit of Liability requested: _____

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 business 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? _____

    d. . Are you supervised by other professionals? ☐ Yes ☐ No Name_____

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

    _____

Previous Professional Experience

Employers Name	Employers Address	Start Date	End Date

Insurance Information

Please list your professional liability policies for the past two years

Company	Policy Limits	Deductible	Retro Date	Policy Period

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

17. 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?	☐	☐

18. Do you assist in Surgery? ☐ ☐
19. Do you administer anesthesia? ☐ ☐
20. Have you changed your field or scope of practice or modified your specialty during the past three years? ☐ Yes ☐ No
    If yes, explain: _____
21. Have you changed the address of your practice during the past three years? ☐ Yes ☐ No
    If yes, list prior address: _____
22. What is the name and version of your EHR (Electronic Healthcare Records) software?
    Please provide a **current** copy of your EHR contract. You may mark out the cost.
23. 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.

Signing this application does not bind Coastal Insurance Company, Inc. 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 Coastal Insurance Company, Inc. about any matter contained in this application, then coverage provided by virtue of this application is void.
Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, have provided Coastal Insurance Company, Inc. (Coastal) information in their insurance application in order for Coastal 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 Coastal with any information, whether written or otherwise, which may be material to evaluating my application for insurance with Coastal. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to Coastal.

I consent for Coastal 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 license**
- **Loss history (Include company loss runs and letters indicating no losses)**

COASTAL INSURANCE COMPANY, INC.
SUPPLEMENTAL CLAIM INFORMATION

INSTRUCTIONS TO THE APPLICANT

A. This form should be completed by the applicant whose signature appears on the Coastal Insurance Company, Inc. Professional Liability Insurance Application.

B. **One of these forms should be completed for each claim or incident in which the applicant has been involved.** If additional forms are needed, applicant may photocopy this form for use in reporting other claims.

C. If space is insufficient to fully provide answers to the questions below, use reverse of this form or separate sheet.

D. Answer all questions completely. Complete information is necessary for the equitable and careful evaluation of your application.

1. Full Name of the Applicant_____

2. Full Name of the Individual(s) of your firm involved in this claim_____

_____

3. Full Name of the Claimant_____ 4. Age:_____ 5. Sex:_____

6. Indicate whether this was a: ☐ Claim ☐ Incident ☐ or Suit

7. Date of Alleged Error_____ 8. Date of Claim_____

9. Additional Defendants_____

_____

10. What is the name of the insurer involved in this claim?_____

11. What is the insurer's claim number assigned to this claim (if known)?_____

12. Description of the claim (please provide enough information to allow for evaluation and use the reverse side of this Sheet if necessary)

Alleged act, error or omission upon which the claimant bases claim:_____

_____

Description of the type and extent of injury or damage allegedly sustained:_____

_____

If claim is closed, answer questions 13 and 14. If claim is pending (open), answer questions 15 through 21.

13. If closed, what was the total loss paid including a deductible that may have applied?_____

14. If closed, was this amount paid subsequent to a: ☐ Court judgment or ☐ Out of court settlement

15. If pending (open), what is claimant's settlement demand? $_____

16. If pending (open), what is defendant's settlement offer? $_____

17. If pending (open), what is insurer's loss reserve? $_____

18. If pending (open), what deductible (if any) applies? $_____

19. If pending (open), is this claim in suit? ☐ Yes ☐ No $_____

20. If claim is in suit, what amount (if any) was asked for in the summons? $_____

21. If pending (open), who is defense counsel (please include address and phone number if known or available?_____

_____

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)

Submit via Email If Signed Electronically

Print