

Nurse Practitioner Application



APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- The application asks that you provide information regarding hospital affiliations, practice associations, etc. This information is requested to provide us with an understanding of your practice but does not mean that a policy, if issued, would cover such entities or persons.
- If you wish to explain any of your answers, please use the Remarks section on page 11. If you need more space, please attach additional pages.
- Please ensure that you sign and date the application on page 12 for California and Rhode Island applicants or page 13 for Alaska applicants.
- Please provide loss runs for the previous ten years, or since the date you began practicing medicine, whichever is more recent. The loss runs must be less than 90 days old.
- Please make a copy of the completed application and supporting documents for your records.
- If you engage in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, you are considered a Covered Entity under HIPAA and thus required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at www.norcalmutual.com.

SECTION I IDENTIFYING INFORMATION

Applicant Name <input style="width:100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-between; font-size: small;"> (Last) (First) (Middle) </div>	Professional Designation <input style="width:100%; height: 20px;" type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <input style="width:100%; height: 20px;" type="text"/> <small>(mm/dd/yyyy)</small>
Primary Practice Address <input style="width:100%; height: 20px;" type="text"/> <input style="width:100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-between; font-size: small;"> (City) (County) (State) (Zip Code) </div>	Telephone # <small>(Including Area Code)</small> <input style="width:100%; height: 20px;" type="text"/> Fax # <small>(Including Area Code)</small> <input style="width:100%; height: 20px;" type="text"/>		
Home Address <input style="width:100%; height: 20px;" type="text"/> <input style="width:100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-between; font-size: small;"> (City) (State) (Zip Code) </div>	Telephone # <small>(Including Area Code)</small> <input style="width:100%; height: 20px;" type="text"/> Fax # <small>(Including Area Code)</small> <input style="width:100%; height: 20px;" type="text"/>		
Applicant E-Mail Address <input style="width:100%; height: 20px;" type="text"/>			

SECTION II COVERAGE INFORMATION

1. Please identify the name of the physician or group under whose professional liability insurance coverage you wish to apply:

(Name of Physician/Group)

NOTE: If your application is approved, you will be added to the physician's or group's policy via endorsement and will share in the physician's or group's limits of liability. Coverage will be extended only while you are acting within the course and scope of your duties for the physician or group and will be subject to the terms, conditions and limitations of the policy.

2. Please describe your association with the physician or group identified above (e.g., employee):
3. Please identify the Requested Effective Date (the date you wish coverage to begin)
 12:01 a.m. Local Time
(mm/dd/yyyy)

NOTE: NORCAL should receive the application at least thirty days before the Requested Effective Date.

SECTION III PRACTICE LOCATIONS

1. Please complete the following regarding all non-hospital locations at which you will render professional health care services as of the Requested Effective Date. Please photocopy this page if additional space is needed.

Name of Location	Address	Location Type (i.e., office, surgery center, nursing home, etc.)
<input style="width:100%; height:100%;" type="text"/>	<input style="width:100%; height: 20px;" type="text"/> <input style="width:100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-between; font-size: small;"> (City) (State) (Zip Code) </div>	<input style="width:100%; height:100%;" type="text"/>
<input style="width:100%; height:100%;" type="text"/>	<input style="width:100%; height: 20px;" type="text"/> <input style="width:100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-between; font-size: small;"> (City) (State) (Zip Code) </div>	<input style="width:100%; height:100%;" type="text"/>
<input style="width:100%; height:100%;" type="text"/>	<input style="width:100%; height: 20px;" type="text"/> <input style="width:100%; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-between; font-size: small;"> (City) (State) (Zip Code) </div>	<input style="width:100%; height:100%;" type="text"/>

SECTION III (con't) PRACTICE LOCATIONS

2. Please complete the following regarding any other non-hospital locations at which you have rendered professional health care services within the past ten years. Please photocopy this page if additional space is needed.

Name of Location	Address	Location Type (i.e., office, surgery center, nursing home, etc.)	Dates
	<input type="text"/> <input type="text"/> (City) <input type="text"/> (State) <input type="text"/> (Zip Code)		From: <input type="text"/> (mm/yyyy) To: <input type="text"/> (mm/yyyy)
	<input type="text"/> <input type="text"/> (City) <input type="text"/> (State) <input type="text"/> (Zip Code)		From: <input type="text"/> (mm/yyyy) To: <input type="text"/> (mm/yyyy)
	<input type="text"/> <input type="text"/> (City) <input type="text"/> (State) <input type="text"/> (Zip Code)		From: <input type="text"/> (mm/yyyy) To: <input type="text"/> (mm/yyyy)

3. As of the Requested Effective Date, will you provide any professional health care services outside the scope of your duties for the physician or group identified in Section II? Yes No

If yes, please complete the following. Please photocopy this page if additional space is needed.

Name of Location	Address	Description of Practice and Hours Per Week	Name of Insurer
	<input type="text"/> <input type="text"/> (City) <input type="text"/> (State) <input type="text"/> (Zip Code)		
	<input type="text"/> <input type="text"/> (City) <input type="text"/> (State) <input type="text"/> (Zip Code)		
	<input type="text"/> <input type="text"/> (City) <input type="text"/> (State) <input type="text"/> (Zip Code)		

4. Please list all hospitals at which you currently maintain or will be applying for staff privileges. Please photocopy this page if additional space is needed.

Name of Facility	Location	Type of Privileges
	<input type="text"/> (City) <input type="text"/> (State)	<input type="checkbox"/> Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: <input type="text"/> <input type="checkbox"/> Pending
	<input type="text"/> (City) <input type="text"/> (State)	<input type="checkbox"/> Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: <input type="text"/> <input type="checkbox"/> Pending

SECTION III (con't) PRACTICE LOCATIONS

Name of Facility	Location	Type of Privileges
<input type="text"/>	<input type="text"/> (City) <input type="text"/> (State)	<input type="checkbox"/> Active <input type="checkbox"/> Provisional <input type="checkbox"/> Courtesy <input type="checkbox"/> Other: <input type="text"/> <input type="checkbox"/> Pending

- If you checked "provisional" or "other," please explain in the Remarks section on page 11.
- If you do not have hospital privileges, please explain why you do not have them and identify the means you use to admit your patients should the need arise:

SECTION IV GENERAL PRACTICE INFORMATION

- Please provide the following based on your work on behalf of the physician or group identified in Section II:

Average number of hours that you will work per week:

Average number of patients that you will care for per week:

Average number of hospital admissions that you will have per week:

SECTION V LICENSES

- Please complete the following regarding *all* states where you are or have been licensed as a health care professional. If a state issued a nurse practitioner certificate in lieu of a license, please also include that information:

State	License Type (e.g., RN or NP)	License Number	Current Status	If Inactive, Reason for Inactive Status
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	<input type="text"/>

- | | | |
|----------------------------|----------------------|--------------------------------------|
| Federal DEA License Number | Current Status | Expiration Date |
| <input type="text"/> | <input type="text"/> | <input type="text"/>
(mm/dd/yyyy) |

SECTION VI

EDUCATION, TRAINING AND CERTIFICATION

1. List all training programs you have entered, whether or not you graduated or completed the training.

Registered Nursing Program:

Name of School	Location	Dates
<input type="text"/>	<input type="text"/> <small>(City)</small>	From: <input type="text"/> <small>(mm/dd/yyyy)</small>
	<input type="text"/> <small>(State)</small>	To: <input type="text"/> <small>(mm/dd/yyyy)</small>

Nurse Practitioner Program:

Name of School	Location	Dates
<input type="text"/>	<input type="text"/> <small>(City)</small>	From: <input type="text"/> <small>(mm/dd/yyyy)</small>
	<input type="text"/> <small>(State)</small>	To: <input type="text"/> <small>(mm/dd/yyyy)</small>

Type of Program (check one):

<input type="checkbox"/> General	<input type="checkbox"/> Adult Psychiatric and Mental Health	<input type="checkbox"/> Pediatric
<input type="checkbox"/> Acute Care	<input type="checkbox"/> Family	<input type="checkbox"/> Women's Health
<input type="checkbox"/> Adult	<input type="checkbox"/> Family Psychiatric and Mental Health	<input type="checkbox"/> Other (specify): <input type="text"/>

Postmaster's Nurse Practitioner Program:
(Type)

Name of School	Location	Dates
<input type="text"/>	<input type="text"/> <small>(City)</small>	From: <input type="text"/> <small>(mm/dd/yyyy)</small>
	<input type="text"/> <small>(State)</small>	To: <input type="text"/> <small>(mm/dd/yyyy)</small>

Other Training:
(Type)

Name of Location	Location	Dates
<input type="text"/>	<input type="text"/> <small>(City)</small>	From: <input type="text"/> <small>(mm/dd/yyyy)</small>
	<input type="text"/> <small>(State)</small>	To: <input type="text"/> <small>(mm/dd/yyyy)</small>

2. Did you successfully complete each training program that you started? Yes No

If no, please explain in the Remarks section on page 11.

3. Please explain any gaps in your training, if applicable, in the Remarks section on page 11.

4. If you *currently* hold a national *nurse practitioner* certification, please identify the certifying organization and specialty/subspecialty area and attach a copy of your certificate:

<input type="checkbox"/> American Academy of Nurse Practitioners	<input type="checkbox"/> National Certification Corporation
<input type="checkbox"/> American Nurses Credentialing Center	<input type="checkbox"/> Other (specify): <input type="text"/>
<input type="checkbox"/> Pediatric Nursing Certification Board	

Specialty Certificate:

Subspecialty Certificate:

NOTE FOR ALASKA APPLICANTS: NORCAL recognizes that Alaska law does not require you to have a supervising physician. Any question below that refers to a supervising physician must still be completed, but should be completed based on the relationship you maintain with the physician or group physicians under whose policy you are applying for coverage (as indicated in Section II).

Supervision/Collaboration

1. Please identify all of your supervising/collaborating physicians:

2. If any one of the physicians identified in question 1 is not the physician or is not a member of the group under whose policy you are applying for coverage (as indicated in Section II), please explain the type of professional relationship that you maintain with the physician(s):

3. Please attach a copy of any written agreement(s) (e.g., standardized procedures, protocols and guidelines) you maintain with your supervising/collaborating physician(s).

How often does the supervising/collaborating physician(s) review these items for updates?

4. Is your supervising/collaborating physician always on-site when you provide services to patients? Yes No

If no, please provide the following in the Remarks section on page 11:

- The location(s) at which you provide services when a physician is not on-site
- The number of hours per week you provide services without the physician on-site
- The approximate frequency with which you consult with the physician regarding cases when he/she is not on site
- The frequency with which the physician visits the office to review medical charts, etc.
- The method of supervision provided when the physician is not on-site
- The maximum distance in miles that the physician is away from the practice

5. If your submitted standardized procedures, etc. does not specify, please identify the method that will be used by your supervising/collaborating physician(s) in supervising the care that you provide:

- The physician will examine at least the following percentage of the patients seen by me **on the same day** I provided the care:

Percentage of patients for whom I provided primary care services: %

Percentage of patients for whom I provided secondary and/or tertiary care services: %

- The physician will review, sign and date at least the following percentage of the medical records of the patients seen by me:

Percentage of patients' medical records for whom I provided primary care services: %

Percentage of patients' medical records for whom I provided secondary and/or tertiary care services: %

Maximum number of days following the encounter within which the review and countersignature will be completed:

- Other (specify):

Procedures and Services

1. If your submitted standardized procedures, etc. does not identify the procedures you perform and services you provide, or does not identify all of them, please attach a separate sheet that identifies all of the procedures and services.

2. Please describe the specialty area of your practice for which you are applying for coverage (e.g., pediatrics):

If you are practicing in a specialty area that is different than the specialty area of the nurse practitioner program you completed, please describe the training that you received in this area(s) and provide proof of that training:

3. Do you perform any procedures or provide any services which are not consistent with the supervising/collaborating physician(s) own expertise and competence? **Yes** **No**

If yes, please identify the procedures or services and explain:

4. Do you perform any procedure in which the patient has been administered an anesthesia other than a topical or local anesthetic? **Yes** **No**

If yes, please provide the following in the Remarks section on page 11:

- Proof of training and hospital privileges for the procedure(s)
- The location(s) where each procedure will be performed
- The qualifications of the individual(s) who will be dedicated to monitoring the patients during the procedures
- The type of physician supervision that will be provided (e.g., direct physical)

5. Do you order, prescribe or dispense any controlled substance? **Yes** **No**

If yes, please identify the level(s):

- Schedule I Schedule II Schedule III Schedule IV Schedule V

If you are applying for coverage in California, and you order or dispense Schedule II or III controlled substances, is it done only in accordance with patient-specific protocols as required by state law? **Yes** **No**

If no, please explain:

Obstetrics

Obstetrics is defined as the care and treatment of pregnancy including, but not limited to, prenatal care, labor, delivery, cesarean section and/or postnatal care.

1. Do you practice obstetrics? **Yes** **No**

If yes, please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> First Trimester Prenatal Care | <input type="checkbox"/> Deliveries (estimated number per year): <input style="width: 100px;" type="text"/> |
| <input type="checkbox"/> Second Trimester Prenatal Care | <input type="checkbox"/> Cesarean Section |
| <input type="checkbox"/> Third Trimester Prenatal Care | <input type="checkbox"/> Other (specify): <input style="width: 200px;" type="text"/> |

Obstetrics (con't)

2. Do you take obstetrical call? Yes No

If yes, please explain:

3. Do you provide professional health care services (not limited to obstetrical care) during delivery (including the immediate labor, puerperium and/or neonatal period) in any facility or any place other than a licensed acute care hospital? Yes No

If yes, please explain:

Drugs, Devices and Clinical Studies

1. Do you use, administer, distribute or prescribe any drugs, pharmaceuticals, devices or equipment disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings? Yes No

If yes:

- a. Please describe:

- b. If the applicable use(s) is/are part of a clinical study, please provide the following information for each clinical study:

- i. A copy of the clinical study's protocol
- ii. Proof of its FDA or IRB approval, if not stamped on the protocol
- iii. A copy of the consent form, if it is not FDA or IRB approved

2. Do you use, administer, distribute or prescribe any FDA-approved drugs, pharmaceuticals, devices or equipment in a manner not approved by the FDA (i.e., off-label use)? Yes No

If yes, are all of your off-label uses supported by appropriate precedent for effectiveness and safety (i.e., within the standard of care)? Yes No

If no:

- a. Identify each drug, pharmaceutical, device and/or equipment, its FDA-approved use and your off-label use:

- b. Provide a copy of the informed consent form that you use for each such off-label use.

Telemedicine, E-mail and Advertising

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine."

1. Do you provide telemedicine services? Yes No

If yes, please explain in the Remarks section on page 11.

SECTION VII (con't) SUPERVISION, PROCEDURES AND SERVICES

Telemedicine, E-mail and Advertising (con't)

2. Do you communicate online/via e-mail with patients and/or potential patients?

If yes, complete 2a - c.

a. Please check all that apply to your practice:

- Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone or other information systems for whom you have performed a good faith prior in-office examination?
- Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone, or other information systems for whom you did **not** perform a good faith prior in-office examination?

b. If you communicate online/via e-mail with patients and/or potential patients with whom you did not perform a good faith prior in-office examination, please explain in the Remarks section on page 11.

c. Do any of the patients with whom you communicate online/via e-mail reside in a state other than the one in which your primary office is located? Yes No

If yes, please explain and identify each state in the Remarks section on page 11.

3. Do you advertise your practice in any way other than listing your name, address and telephone number in the telephone book? Yes No

If yes, please submit copies of all of your advertisements (excluding those that appear on your website, if applicable) and/or the script of any voice, film or TV media.

4. Is there a website related to your practice? Yes No

If yes, what is the website address(es):

Miscellaneous

1. When you see a patient for the first time, do you always verbally identify yourself as a nurse practitioner? Yes No

If no, please identify the means you use to ensure that your patients are aware that they are being treated by a nurse practitioner and not a physician:

SECTION VIII SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed written narrative (including, but not limited to, date of occurrence, reason for occurrence and resolution) and pertinent documentation (e.g., nonrenewal or declination notice, medical board documents, letters from hospital, diversion program, treating physician, etc.).

- 1. Has any professional liability insurance company **ever** canceled, nonrenewed or modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) your insurance, declined to offer you coverage or notified you of its intent to pursue such action? Yes No
- 2. Has your license to practice as a health care professional in any jurisdiction, your DEA registration, or any applicable controlled substance license or registration in any jurisdiction **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, fined, subject to probationary terms or conditions or otherwise investigated or limited in any way? Yes No
- 3. Has any governmental agency **ever** investigated you, placed you on probation, suspended you or taken any action against you? Yes No

SECTION VIII (con't) SUPPLEMENTAL QUESTIONS

4. Have your clinical privileges, memberships, contractual participation in or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions or otherwise investigated or limited in any way for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? Yes No
5. Have you **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges with; terminated contractual participation or employment in; or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes No
6. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations? Yes No
7. Have you **ever** been charged with, been convicted of or admitted to committing a felony? Yes No
8. Have you **ever** been accused of sexual misconduct? Yes No
9. Have you **ever** had any contact of a sexual nature with a patient or former patient? Yes No
10. Have you **ever** had a problem with, been evaluated for, been diagnosed with, been treated for or are currently being treated for alcohol, narcotic or any other substance addiction, sexual addiction or mental illness? Yes No
11. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice? Yes No

SECTION IX CLAIMS HISTORY

1. Within the past ten (10) years has a malpractice claim or suit been brought against you, or have you been notified of your involvement in a malpractice claim or suit, either directly or indirectly? Yes No
2. To your knowledge, within the past ten (10) years has a malpractice claim been brought against any organization (e.g., medical group, hospital, etc.) as a result of your rendering or failing to render professional health care services? Yes No
3. Are you aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against you, directly or indirectly, even if you believe the claim or suit would be without merit? Yes No

If you answered yes to questions 1, 2 or 3, please complete a Claim Information Form for each applicable claim, suit, incident, conduct, etc.

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (e.g., 2, 3b). Please photocopy this page if additional space is needed:

Page Number	Question Number	Remarks

Please provide any additional information material to the risk that has not otherwise been addressed in this application:

FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY

Warranties and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to the physician or group by NORCAL ("the Company").

I understand it is my responsibility to obtain and review a copy of the insurance policy. I also understand I may ask any questions about any policy language that is not clear to me.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that the physician's or group's policy (including my coverage), if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that, in the event my coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payer).

I understand that I (or the physician's or group's Authorized Representative) must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf, including changes in my partners or associates, medical license, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

I understand that if my application is approved and I am added to the physician's or group's policy, coverage would be extended only while I am acting within the course and scope of my duties for the physician or group, subject to the terms, conditions and limitations of the policy.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about me.

Signature

Date

(mm/dd/yyyy)

Name (Print)

FOR ALASKA APPLICANTS ONLY

Representations and Authorization to Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to the physician or group by NORCAL ("the Company").

I understand it is my responsibility to obtain and review a copy of the insurance policy. I also understand I may ask any questions about any policy language that is not clear to me.

I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that the physician's or group's policy (including my coverage), if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that, in the event my coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payer).

I understand that I (or the physician's or group's Authorized Representative) must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf, including changes in my partners or associates, medical license, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

I understand that if my application is approved and I am added to the physician's or group's policy, coverage would be extended only while I am acting within the course and scope of my duties for the physician or group, subject to the terms, conditions and limitations of the policy.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about me.

Signature

Date

(mm/dd/yyyy)

Name (Print)

CLAIM INFORMATION FORM

Name of Patient:

Gender: Male Female

Age of Patient (at time of treatment):

Name of Claimant (if different than patient):

Your Relationship to Patient (e.g., health care provider or consultant):

Allegation:

Location of Incident:

Additional Defendants:

Date (mm/dd/yyyy) Incident or Claim Was Reported to the Insurance Company:

Name of Insurance Company:

Disposition or Current Status of the Incident, Claim or Suit:

- Open
- Incident has been reported but claim or suit has not been filed
 - Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
 - Claim or suit is currently in arbitration or mediation or is being tried in court
 - Settlement has been made or judgment returned but remains open

Closed Date Closed (mm/dd/yyyy):

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in your favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made):

Amount paid on your behalf (if different):

Total verdict amount (if different than total loss payment amount):

CLAIM INFORMATION NARRATIVE

Please describe your care and treatment of the patient. Attach additional pages as needed. Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and must include the following information:

- Condition and diagnosis at time of treatment
- Dates and a description of treatment rendered
- Condition of patient subsequent to treatment
- Copies of patient(s) chart(s) and operative report(s) as appropriate

I understand the information submitted herein becomes part of my insurance application as submitted.

Signature

Date

(mm/dd/yyyy)

Name (Print)