VERUS UNDERWRITING MANAGERS | a Berkley Company

PROFESSIONAL LIABILITY APPLICATION FOR CERTIFIED REGISTERED NURSE ANESTHETIST – CRNA STAFFING

COMPLETE IN ADDITION TO ACORD APPLICATIONS.
ATTACH ADDITIONAL SHEETS AS NECESSARY.
ANSWER ALL QUESTIONS. IF NOT APPLICABLE, INDICATE N/A

PART I. GENERAL INFORMATION

1. a. Name of Applicant (including DBAs): _____

   b. Tax ID/SSN: _____

   c. Mailing Address: _____

   d. Location Address(es): _____

   _____

   _____

   e. County (parish) of each Location: _____

   _____

   _____

   f. Telephone Number: Office: _____ Fax: _____

   g. Person to contact for survey: Name: _____ Title: _____

   h. Year Entity established: _____

   i. Entity is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Professional Association/Corporation

   ☐ Other; Describe: _____

   j. Entity is: : ☐ For profit ☐ Non-profit

   Describe source of funds: _____

   k. Entity is:
   ☐ Medical Personnel Staffing (Home Health Care services only)
   ☐ Medical Personnel Staffing (All Other)
   ☐ Other; Describe: _____

   l. Accreditation Information (check whichever applies):

   ☐ SAS Distinguished or Gold Standards ☐ SAS Full Accreditation

   ☐ Other; Describe: _____

   m. Proposed Effective Date: _____

   n. Requested Limits of Liability (if available):

Professional Liability	$ _____	$_____
General Liability	$ _____	Each Occurrence
	$ _____	General Aggregate

   o. Annual Gross Receipts: Est. next 12 months: $ _____ Last 12 months: $ _____

   p. Total premises square footage occupied by applicant: _____

   q. List all memberships in professional organizations: _____

PART II. EXPOSURES

2. a. Indicate the next 12 months estimated hours worked and compensation for employed staff:

Employed Staff (W-2):

Type	Maximum #	Annual Hours of Service	Annual Payroll
CRNA	_____	_____	$ _____
Assistant Anesthetist	_____	_____	$ _____
Other:	_____	_____	$ _____
Employed Subtotal	_____	_____	**$** _____

Contracted Staff (1099):

Type	Maximum #	Annual Hours of Service	Annual Payroll
CRNA	_____	_____	$ _____
Assistant Anesthetist	_____	_____	$ _____
Other:	_____	_____	$ _____
Contracted Subtotal	_____	_____	**$** _____
Total	_____	_____	**$** _____

b. Does the applicant desire to provide coverage for independent contractor(s) – including them as additional insured(s) on your policy while working on your behalf? ☐ Yes ☐ No

c. Enter percentage of services provided by category of staff, including contracted staff:

CRNAs

_____% Hospitals
_____% Surgicenters
_____% Other; Describe: _____

Other: _____

_____% Hospitals
_____% Surgicenters
_____% Other; Describe: _____

Assistant Anesthetist

_____% Hospitals
_____% Surgicenters
_____% Other; Describe: _____

Other: _____

_____% Hospitals
_____ Surgicenters
_____% Other; Describe: _____

d. Number of estimated patients next 12 months: _____

e. Number of patients last 12 months: _____

f. Is your facility owned by an M.D.? ☐ Yes ☐ No
If yes, what is the owner's name? _____

g. Do you sell, rent, or otherwise provide any equipment or products to patients? ☐ Yes ☐ No
Do you sell, rent, or otherwise provide any equipment or products to others? ☐ Yes ☐ No
If yes to either question, please complete the Product Sales/Rental Supplemental Application.

h. Is the applicant eligible for certification or accreditation? ☐ Yes ☐ No
If yes, is the applicant certified and/or accredited? ☐ Yes ☐ No
If no, explain the reason:
_____

i. Is applicant approved to receive Medicare and Medicaid payments? ☐ Yes ☐ No

PART III. RISK MANAGEMENT

3. a. Please list the Medical Director's name, qualifications and number of years of experience:
Name:_____ Title: _____
Experience/Training: _____
Association Membership: _____

b. Does your agency have a written credentialing policy and procedure for all individuals associated with or practicing within the agency? ☐ Yes ☐ No

c. Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No

d. Does the staff supervisor make regular audit visits of staff in the field? ☐ Yes ☐ No
Who does the supervising of staff, and what is his/her experience?
_____

e. Do you require contracted staff (if any) to carry their own Professional Liability Insurance? ☐ Yes ☐ No
Do you secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No

f. Describe the referral source(s) by which patients are directed to the entity:
_____

g. Do you enter into any contractual agreements (other than lease of premises agreements) in which you hold others harmless? If yes, attach copies of all such contracts. ☐ Yes ☐ No

h. Does the agency advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. ☐ Yes ☐ No

i. Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ☐ Yes ☐ No

j. Is any staff provided to hospitals specifically to serve a particular specialty (e.g., OR, ICU, CCU, ER, etc)? ☐ Yes ☐ No
If yes, enter percentage of services provided, by category, of staff including contracted staff:
_____% OR
_____% Labor/Delivery
_____% ICU/CCU
_____% ER
_____% Other; Describe:_____

k. Does your agency have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No

l. Does your facility require the professional staff be trained in CPR? ☐ Yes ☐ No

m. Do you prepare job descriptions and instructional manuals for your staff? If yes, enclose a copy of each. ☐ Yes ☐ No

n. Do you maintain records of specific areas of experience of each staff member? ☐ Yes ☐ No

o. Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. ☐ Yes ☐ No

p. Has the applicant or any of its employees:
1. Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? ☐ Yes ☐ No
2. Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐ Yes ☐ No
3. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
If the answer to any question in p. is yes, please attach a detailed explanation.

q. Please describe in detail any additional operations, business pursuits, or joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health operations. ☐ None ☐ Description attached

PART IV. HISTORY

4. a. List prior professional liability insurers for the past five years, starting with the most recent year: If none, state none.

	Insurer	Policy #	Limits of Liability	Premium	Eff. Date	Claims Made?
1.	_____	_____	_____	_____	_____	☐ Yes ☐ No
2.	_____	_____	_____	_____	_____	☐ Yes ☐ No
3.	_____	_____	_____	_____	_____	☐ Yes ☐ No
4.	_____	_____	_____	_____	_____	☐ Yes ☐ No
5.	_____	_____	_____	_____	_____	☐ Yes ☐ No

If Claims Made, what is the most recent retroactive date? _____

b. List prior general liability insurers for the past five years, starting with the most recent year. If none, state none

	Insurer	Policy #	Limits of Liability	Premium	Eff. Date	Claims Made?
1.	_____	_____	_____	_____	_____	☐ Yes ☐ No
2.	_____	_____	_____	_____	_____	☐ Yes ☐ No
3.	_____	_____	_____	_____	_____	☐ Yes ☐ No
4.	_____	_____	_____	_____	_____	☐ Yes ☐ No
5.	_____	_____	_____	_____	_____	☐ Yes ☐ No

If Claims Made, what is the most recent retroactive date? _____

c. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐ Yes ☐ No
If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved. (attach an additional sheet if necessary)
_____

d. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in c. above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? ☐ Yes ☐ No
If yes, describe the event and indicate the reason for anticipation of a claim:
_____

FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 that person to criminal and civil penalties (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.) **(Not applicable in AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OK, OR, PA, PR, RI, TN, VA, WA, WV)**

Applicable in Alabama, Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, and West Virginia: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

Applicable in California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Florida and Oklahoma: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony. (In FL, a person is guilty of a felony of the third degree.)

Applicable in Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Applicable in Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Applicable in Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

REPRESENTATIONS

Verus Underwriting Managers, a Berkley Company, is authorized to make any inquiry in connection with this application. Signing this application does not bind Verus Underwriting Managers or the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application, and all previous applications and material changes thereto of which Verus Underwriting Managers or the Company receives notice is on file with Verus Underwriting Managers and is considered physically attached to and part of the policy if issued. Verus Underwriting Managers and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Verus Underwriting Managers, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I/We warrant to Verus Underwriting Managers and the Company, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should Verus Underwriting Managers and the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Verus Underwriting Managers or the Company.

It is understood and agreed that prior to the inception date of the policy no applicant knew, nor could have reasonably foreseen, any negligent act, error or omission or breach of professional duty, or personal injury or other circumstances that reasonably might result in a Claim covered by this policy.

Name of Applicant:		
Signature of person authorized to execute on behalf of the applicant:		**Date:**
Print Name and Title of person authorized to execute on behalf of the applicant:		
Name and address of Broker:		

A copy of this application should be retained for your records.