



CRNA
CERTIFIED REGISTERED NURSE ANESTHETIST
PROFESSIONAL LIABILITY APPLICATION
CLAIMS-MADE COVERAGE

Please complete this application and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued. To use this form, you may mouse click on a field or move between fields by using the tab key.

GENERAL INFORMATION

Full Name: _____	Date of Birth: _____
DBA/Corp Name: _____	Mailing Address: _____
Phone: _____	City: _____
Email: _____	State: _____ Zip: _____

EDUCATION AND LICENSURE

CRNA School: _____ Month/Year of Completion: _____

License Number/State Certification: _____

If you are licensed in more than one state, please indicate which states: _____

Indicate the number of CME hours you have completed in the last two years: _____ Are you ACLS Certified? Yes No

APPLICANT PRACTICE INFORMATION

1. Coverage is required for which type of practice: Full-time Part-time Moonlighting
2. How many hours do you practice per week? _____ If moonlighting, how many hours do you practice per year? _____
3. How many average weekly patient encounters? _____
4. Please indicate the approximate percentage of your patients:

Bariatric	_____ %	Plastic/Cosmetic	_____ %
Dental/Oral Surgery	_____ %	Podiatric	_____ %
Obstetric	_____ %	General Surgery	_____ %
Pediatric	_____ %	Pain Management	_____ %
Ophthalmologic	_____ %	Endoscopic	_____ %
Other	_____ %		
5. What percentage of your practice constitutes general anesthesia procedures? _____ %
6. Are you supervised by an Anesthesiologist or physician at each location? Yes No
7. Is an Anesthesiologist or physician available on premises at all times? Yes No
8. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? Yes No*
9. During administration of all anesthetic, do you use a pulse oximeter monitor? Yes No*
10. During all anesthetics:
 - a) Is an electrocardiogram continuously displayed? Yes No*
 - b) How often is arterial blood pressure determined and evaluated? _____
 - c) How often is heart rate determined and evaluated? _____
 - d) How is circulatory function evaluated? _____
11. During all general anesthetics, do you use an end tidal CO2 monitor? Yes No*

12. During all general anesthesia using an anesthesia machine do you:

a) Use an oxygen analyzer with a low concentration limit alarm? Yes No*

b) Test proper functioning of alarms prior to each use? Yes No*

13. When ventilation is controlled by a mechanical ventilator, do you:

a) Use a device equipped with a full set of safety alarms? Yes No*

b) Test proper functioning of alarms prior to each use? Yes No*

* Explain any **NO** answers to questions 8-13 below:

14. Do you reuse the same needle or syringe when administering intravenous medications? Yes* No
 *If **YES**, please provide a description: _____

15. Within the last five years, have your practice's characteristics, procedures performed, or business associations changed? Yes* No
 *If **YES**, please provide a description: _____

16. Do you anticipate any changes in your practice this year? Yes* No
 *If **YES**, please provide a description: _____

17. Do you now or have you ever treated prisoners in a State, Federal or any correctional institution? Yes* No
 *If **YES**, please provide a description: _____

18. Do you treat patients in a nursing home or similar care facility? Yes* No
 *If **YES**, please provide a description: _____

19. Do you provide services to a sports team? Yes* No
 * If **YES**, please check all that apply: High School College Professional

20. Do you currently have professional liability coverage that the policy for which you are applying will replace? Yes No

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Retroactive Date	Premium
				Claims-Made* Occurrence		

*If Claims-Made is selected, please provide a Retroactive Date. If Occurrence is selected, please skip Retroactive Date.

PRACTICE LOCATIONS—List all practice locations. Attach a separate page, if necessary.

Name of Practice	Street Address	City	State	Zip

HOSPITAL STAFF PRIVILEGES—List all hospitals in which you have privileges. Attach a separate page, if necessary.

Name of Hospital	Street Address	City	State	Zip

COVERAGE REQUESTED

Effective Date: _____ Per Claim
 \$ _____

Retroactive Date*: _____ Limits of Liability Annual Aggregate
 \$ _____

*Please provide evidence of coverage back to retroactive date requested. Please identify and explain any gaps in coverage.

APPLICANT PRACTICE HISTORY

- | | | | |
|----|--|------|----|
| 1. | Has your license to practice medicine or dispense narcotics ever been investigated, denied, revoked, suspended, voluntarily surrendered or subject to probationary terms? | Yes* | No |
| 2. | Have the privileges of your hospital or surgery center ever been investigated, denied, revoked, suspended, voluntarily surrendered or subject to probationary terms (other than as a new healthcare provider)? | Yes* | No |
| 3. | Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? | Yes* | No |
| 4. | Have you ever had a complaint or claim brought against you for sexual misconduct? | Yes* | No |
| 5. | Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of any circumstances that might lead to such a claim or suit? | Yes* | No |
| 6. | Are you aware of any request for medical records by a patient or attorney that might result in a claim? | Yes* | No |
| 7. | Have you ever practiced without professional liability insurance? | Yes* | No |
| 8. | Have you ever had any insurance company decline, cancel, rescind, or non-renew a professional liability insurance policy? (Response not required in the state of Missouri.) | Yes* | No |

*If the response to any question above is **YES**, please provide an explanation.

PLEASE REVIEW AND SIGN**FRAUD WARNING**

Notice to Applicants of all states except Kentucky, Louisiana, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Puerto Rico, Virginia and Washington D.C.:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 the person to criminal and civil penalties and denial of insurance benefits.

Notice to Kentucky Applicants:

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.

Notice to Louisiana Applicants:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Jersey Applicants:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New Mexico Applicants:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to New York Applicants:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each provision.

Notice to Oregon Applicants:

Any person who knowingly and with intent to defraud or deceive any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto upon which the insurance company or any other person relies may be a crime and may provide grounds for criminal or civil penalties.

Notice to Pennsylvania Applicants:

Any person who knowingly and with intent to defraud any insurance company or other person who, files an application for insurance or a statement of claim 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 such person to criminal and civil penalties.

Notice to Puerto Rico Applicants:

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 by 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.

Notice to Virginia Applicants:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Washington D.C. Applicants:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances, or events, which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states and is not subject to the financial solvency regulation and enforcement, which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

The applicant must sign this Application within 45 days prior to the policy Inception date.

Signature of Applicant

Date

Print or Type Name and Title