Connecticut Medical Insurance Company

Somerset Square
80 Glastonbury Boulevard
P.O. Box 71
Glastonbury, CT 06033
860.633.7788
(CT only) 800.228.0287
Fax: 860.633.8237
(CT only) 800.403.3580

Application for Nurse Practitioner/Advanced Practice Registered Nurse
(To apply for this coverage you must be employed by a CMIC insured physician)

Occurrence Policy

Please type or print.

I. PERSONAL INFORMATION

A. ____________________
Applicant Name (First, Middle, Last, Professional Designation)

B. ____________________
Home Address

C. Social Security Number ________-________-________ D. Date of Birth _______/_______/_______

E. Home Telephone Number (   ) ______-________ F. Professional Specialty ____________________

II. PROFESSIONAL INFORMATION

A. ____________________ B. Employment Date _______/_______/________
Name of Employer/Medical Specialty

C. ____________________ D. Telephone Number (   ) _______-__________
Address of Employer

E. List below **all** locations where you practice. Please include name and address.

____________________ Hours/Week ______________

____________________ Hours/Week ______________

F. Desired Effective Date of Coverage _______/_______/________

G. Desired limits of liability (Check one choice): ☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

H. 1. CT License No. ____________________ APRN License Number ____________________

2. Are you licensed in any other State(s)? ☐ Yes ☐ No If Yes, which State(s)? ____________________

I. Name of national certifying organization? ____________________

J. Specify the educational programs, internships or clinicals you have completed in order to practice in your field.

____________________ Date completed _______/_______/________

____________________ Date completed _______/_______/________

K. Of what professional associations are you a member? ____________________

III. UNDERWRITING INFORMATION

A. Do you now or have you ever had any chronic physical defect or any mental or emotional illness or disorder which impaired or could impair your practice to any degree? ☐ Yes ☐ No

B. Do you now or have you ever had a drug or alcohol addiction? ☐ Yes ☐ No

C. Has any claim or suit for alleged malpractice ever been brought against you or any present or past employer for an act or omission involving your services? ☐ Yes ☐ No

D. Are you aware of any circumstances that might reasonably lead to such a claim or suit even if you believe the possible claim or suit would be without merit? ☐ Yes ☐ No

Give full details to any “Yes” answers to Questions A, B, C and D on a separate sheet.

Please read the following carefully, then sign and date the application in the space provided below.

I HEREBY DECLARE that all statements and answers herein are full, complete and true to the best of my knowledge and belief, and that I have not withheld or omitted any material circumstance or information concerning the subject matter of the questions asked.

I AGREE to notify the Connecticut Medical Insurance Company (“Company”) promptly of any material changes in the information I have provided herein. **I UNDERSTAND** that the statements and answers herein will be relied upon by the Company and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE the release and exchange of information regarding my insurance coverage and any changes herein between the Company and any and all hospitals where I have privileges or any other institution to which the Company provides a Certificate of Insurance. This authorization does not impose any obligation on the Company to release or exchange such information.

DISCLOSURE AUTHORIZATION

I AUTHORIZE all professional societies, my prior or present business or medical associates, licensing boards, hospitals, governmental entities, past or present professional liability insurers, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made by me herein to release such information to the Connecticut Medical Insurance Company and its employees, officers, agents, directors and other representatives for use in making underwriting decisions or in considering risk management issues. **I AUTHORIZE** the Connecticut Medical Insurance Company and such representatives to use a copy of this authorization in place of the original.

This authorization shall be valid for the period during which I am insured by or am seeking insurance from the Connecticut Medical Insurance Company. I understand that upon request, I (or a person authorized to act upon my behalf) am entitled to receive a copy of this authorization.

______________________________ ______________

Signature of Applicant Date

PLEASE ATTACH A COPY OF YOUR COLLABORATIVE PRACTICE AGREEMENT

Are you aware of and in compliance with Connecticut General Statute (CGS) Sec. 20-87 Advanced Practice Registered Nurse and the defined role of the collaborating physician? ☐ Yes ☐ No If no, you may obtain a copy of the statute by calling CMIC.

______________________________ ______________

Signature of Employer/Collaborating Physician Date

______________________________ ______________

Underwriting Manager Approval Date