YELLOWSTONE
INSURANCE EXCHANGE, RRG

Quick Underwriting Checklist for Individuals Completing Allied Healthcare Application

Please complete each item on the checklist prior to submitting the application.

1. □ Application completed

2. □ Pages 4, 5 and 6 of the application signed and witnessed. (Page 5 must be signed and witnessed even if no claims.)

3. □ CV

4. □ **Licenses**
   a. □ Copies of all state licenses
   b. □ Copies of DEA, ACLS, PALS, ATLS and BLS

5. □ Copies of all Certificates of Insurance
   ***Certificate of Insurance- A document providing evidence that certain types of insurance coverages and limits have been purchased for a specific period of time by the party required to furnish the certificate.**

6. □ Loss Runs/Claims Histories from each carrier for every employer during the last 5 consecutive years
   ***Claim Loss Runs- A periodic report of claims information provided by insurance companies to their insureds. Please note that the National Practitioner Data Bank (NPDB) is not an acceptable loss run. Page two of this document can be sent to your insurance providers. Please fill out page two and send to you insurance providers for the last 5 years.**

7. □ Three written professional references

8. □Any mid-level individual working in the emergency department should have ACLS and PALS certifications. It is also highly recommended they have a ATLS when working in the ED.

9. □ When working in the clinic, they should have an ACLS certification.

10. □ For inpatient care an ACLS is required and PALS is recommended.

11. □ Yellowstone will ask each mid-level individual to have these certifications by their Yellowstone renewal date or one year upon entry into the company.

Your Contact Information:

Name:	
Email:	
Phone Number:	

The information above is complete and i have attached all necessary documents requested.

Signature (X) _____ Date: _____

***Definitions to assist with application completion: (source: International Risk Management Institute)**

Please e-mail or fax the completed and signed application with supporting documentation to:

Yellowstone Insurance Exchange, RRG
Attn: Underwriting
E-mail- underwriting@yierrg.com
Fax- 866-216-7434
Tel- 866-216-7433

Yellowstone Insurance Exchange, RRG
APPLICATION FOR ALLIED HEALTHCARE INDIVIDUAL (CLAIMS MADE)

PLEASE TYPE OR PRINT LEGIBLY

Personal Information

Requested Coverage Effective Date: _____

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) _____
5. E-mail _____
6. County _____
7. Principle Correspondence Address _____
8. Social Security No. _____
9. Business Phone _____
10. Home Phone _____
11. Your Profession _____
12. Licensed/Certified by _____ No. _____
13. Name of Hospital where you are or will be employed _____
    a. Are you going to be a W2 employee of the hospital? ☐ Yes ☐ No
    b. Date of Employment _____
    c. What department? _____ How many hours a week will you be on duty? _____

Education and Training

14. Indicate your educational background (attach a copy of your Curriculum Vitae)

	Location	Degree	Date
a. School			
b. Other			
c. Post Graduate			
d. Add'l Degrees or Training			

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

Previous Professional Experience

Employer's Name	Employer's Address	Start Date	End Date

Insurance Information

16. **Please list your professional liability policies for the past five years.**

Company	Policy Limits	Deductible	Retro Date					Policy Period
				Claims Made	◯	Occurrence	◯	
				Claims Made	◯	Occurrence	◯	
				Claims Made	◯	Occurrence	◯	

If at any time you were without insurance, please indicate on a separate sheet of paper.

17. Did you purchase an Extended Reporting Endorsement (tail coverage)? ◯ Yes ◯ No

18. Are you employed by, or are you an independent contractor for physicians or dentists? ◯ Yes ◯ No

If "Yes", list all physician and dentist names, where they are insured, limits of liability, and policy expiration dates.

Name	Insurer	Limits	Policy Expiration

19. Have you ever: **(Explain any "Yes" answers on a separate sheet of paper)**

	Yes	No
a. Been diagnosed/treated for alcoholism, narcotics addiction or mental illness?	○	○
b. Been convicted of any civil or criminal act by any State or Federal authority?	○	○
c. Had a complaint filed against you by any State Board of Medicine?	○	○
d. Had any State medical license or certification revoked, restricted, limited, denied, suspended, subject to probationary conditions, voluntarily relinquished or otherwise sanctioned?	○	○
e. Had your defined hospital staff or similar privileges refused, modified, suspended or voluntarily surrendered?	○	○
f. Had your membership in a professional society refused, modified, suspended or revoked?	○	○
g. 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. Had professional liability insurance refused, cancelled or non-renewed?	○	○
i. Been diagnosed as having tested positive for Hepatitis B?	○	○
j. Tested for the antibody?	○	○
k. Been diagnosed as having or tested positive for HIV or Acquired Immunodeficiency Syndrome?	○	○
20. Do you assist in Surgery?	○	○
21. Do you administer anesthesia?	○	○
a. Are you supervised?	○	○
b. Are you unsupervised?	○	○
22. Do you perform normal deliveries?	○	○
23. Do you have any other specialized training?	○	○
If "Yes", give details: _____		
24. Have you changed your field or scope of practice or modified your specialty during the past three years?	○	○
If "Yes", explain: _____		
25. Have you changed the address of your practice during the past three years?	○	○
If "Yes", list prior address: _____		
26. 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?	○	○
If "Yes", please provide details on a separate sheet of paper.		

Applicant must sign and have witnessed pages 4, 5 and 6.

Notice: Failure to provide complete and accurate information regarding actual claims, suits, incidents, acts, errors, or omissions which could reasonably be expected to become the basis of a claim or suit will result in no coverage under the policy.

Signing this application does not bind **Yellowstone Insurance Exchange, RRG** 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 **Yellowstone Insurance Exchange, RRG** about any matter contained in this application, then coverage provided by virtue of this application is void.

Date:_____

(X)_____
(Applicant)

(X)_____
(Witness)

About Your Application Submission

Please make certain to refer back to the Application Checklist provided to ensure you have completed each item in the checklist prior to submission of the application to Yellowstone Insurance Exchange, RRG. The quality of your application submission enables underwriting to more quickly process your application and deliver your policy to you in a timely manner. Yellowstone is committed to continuous improvement and enhancing the level of service it provides to members.

Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.

Supplemental Claim Information

This form must be signed and dated even if there are zero claims.

Instructions To The Applicant

As indicated on Question 19g of the **Yellowstone Insurance Exchange, RRG** Allied Healthcare Provider Professional Liability Application, the following information is required. Please complete a separate form for each claim or suit reported.

1. Name, age and sex of patient: _____
2. Date of first consultation: _____
3. Physical condition and diagnosis at above date: _____
4. Dates of treatment given and nature of same: _____
5. Date of claim, and allegations made against you: _____
6. Disposition of claim, amount of judgment or settlement: _____
7. What insurance company, if any was involved? _____
8. Subsequent condition or health of patient: _____
9. Names of others, doctors, if any, involved in the claim or suit: _____
10. To whom may we refer for further information about the suit? _____

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)

Yellowstone Insurance Exchange, RRG

Authorization For Release Of Information

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

I consent for **Yellowstone Insurance Exchange, RRG** 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)