

# Nautilus Insurance Company

## Application for Professional and General Liability Insurance *Emergency Medical Services- Medical Director*

**APPLICATION CHECKLIST - PLEASE INCLUDE THE FOLLOWING INFORMATION WITH THE APPLICATION:**

1. COPIES OF ALL EMS MEDICAL DIRECTOR CONTRACTS WITH MUNICIPALITIES OR OTHER ENTITIES INTENDED FOR COVERAGE, IF AVAILABLE
2. PROOF OF MEDICAL MALPRACTICE INSURANCE IF THE APPLICANT ALSO IS A PRACTICING PHYSICIAN
3. CURRENT CURRICULUM VITAE - ATTACH TO APPLICATION AND CHECK HERE:
4. EMS DIRECTOR JOB DESCRIPTION
5. PLEASE TYPE OR PRINT IN INK

**THE COVERAGE IS ON A CLAIMS MADE AND REPORTED BASIS.  
PLEASE READ THE COVERAGE CAREFULLY.**

*The coverage being applied for is NOT intended to replace standard Medical Malpractice Insurance if the Applicants are physicians in private practice or are employed as physicians in addition to their duties as an EMS Medical Director. Please read the policy carefully.*

Whenever printed in this Application, the terms in boldface type shall have the same meanings as indicated in the Policy.

1. Applicant's Name:

First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_ DBA \_\_\_\_\_

Home  Office

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

2. Applicant is:  Individual  Corporation  Professional Association  Other: \_\_\_\_\_

3. If applicable, what is the Date of Incorporation: \_\_\_\_\_  
(Month/Day/Year)

4. Does the Applicant currently carry insurance as an EMS Medical Director?  Yes  No  
If "Yes," please provide a copy of the Applicant's policy declarations.

5. Limits for Professional Liability desired:  \$1,000,000/\$3,000,000  Other:\$ \_\_\_\_\_

a. Effective Date Desired: \_\_\_\_\_ b. Retroactive Date Desired: \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

6. Does the Applicant want to purchase General Liability coverage?  Yes  No

a. Effective Date Desired: \_\_\_\_\_ b. Retroactive Date Desired: \_\_\_\_\_  
(Month/Day/Year) (Month/Day/Year)

# NAUTILUS INSURANCE COMPANY

7. Is the Applicant a licensed physician in Good Standing?  Yes  No

License #	State	Expiration Date	% of practice in this state

8. Practitioner DEA Number: \_\_\_\_\_

### Medical Specialty Information:

9a. Principal Medical Specialty in which the Applicant practices: \_\_\_\_\_

9b. Percent of practice time: \_\_\_\_\_ %

9c. Sub-Specialty in which the Applicant practices: \_\_\_\_\_

9d. Percent of practice time: \_\_\_\_\_ %

10a. Has the Applicant completed an EMS fellowship?  Yes  No

10b. If "Yes," please describe: \_\_\_\_\_

11. List the states where the applicant is an EMS Medical Director: \_\_\_\_\_

12. Date the Applicant first became an EMS Medical Director: \_\_\_\_\_

13a. Is the Applicant a State or regional EMS Medical Director?  Yes  No

13b. If "Yes," please submit a copy of the Applicant's EMS Medical Director contract/job description.

14a. Is the Applicant a member of the National Association of EMS Physicians (NAEMSP) or any other professional association?  Yes  No

14b. Please list any associations other than the NAEMSP: \_\_\_\_\_

15a. Is the Applicant employed outside of their duties as an EMS Medical Director?  Yes  No

15b. If "Yes," check the appropriate boxes:  Hospital Emergency Department  Urgent Care Facility  
 Faculty  Other: \_\_\_\_\_

15c. Duties: \_\_\_\_\_  
 Full-Time  Part-Time

16a. Does the Applicant carry Physician's Medical Malpractice Insurance for the above duties?  Yes  No

16b. If Yes, attach a copy of the certificate of insurance or indicate if coverage/indemnification is provided to the Applicant by their employer.

**NOTE: If the Applicant is a general/family practice physician, proof of insurance is REQUIRED.**

16c. If "No," please provide an explanation. \_\_\_\_\_

**NOTE: The rendering of medical services outside the Applicant's capacity as an EMS Medical Director is specifically excluded from coverage for which the Applicant is applying.**

### Has the Applicant:

17a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association?  Yes  No

17b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No

17c. Ever been treated for alcoholism or drug addiction?  Yes  No

17d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  Yes  No

17e. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? (not allowed in MO)  Yes  No

# NAUTILUS INSURANCE COMPANY

- 17f. Ever had the Applicant's hospital privileges denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or been subjected to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry?  Yes  No
- 17g. Had any malpractice claim or suit brought against the Applicant within the past ten (10) years?  
**If "Yes," please complete the Claim/Circumstance/Administrative Hearings Supplement for each claim/suit brought against the Applicant in the past and submit complete copies of all office/hospital records, summons and complaint, etc.**  Yes  No
- 17h. Had any professional liability and/or Employment Practices Liability claims or incidents been made against the Director, the applicant, or anyone proposed for this insurance?  
 If "Yes," how many? \_\_\_\_\_  Yes  No  
 If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.
- 17i. Been made aware of any facts or circumstances, which might give rise to a medical malpractice, professional liability or Employment Practices Liability claim or complaint?  
 If "Yes," how many? \_\_\_\_\_  Yes  No  
 If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.
- 17j. Been made aware of any charges, inquiries, investigations, grievances or other administrative or disciplinary hearings?  
 If "Yes," how many? \_\_\_\_\_  Yes  No  
 If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.
18. Is a temporary medical director available to handle your responsibilities in the event of your absence?  Yes  No  
 If "Yes," please provide details: \_\_\_\_\_
19. Does the Applicant have Allied Healthcare Personnel in their employment?  Yes  No  
 If "Yes," have each of the Applicant's employed Allied Health Personnel complete an Employee Supplement and attach a copy of licensure and certification for each.
20. Complete the following for each separate contract or entity for which coverage is desired.

Medical Director Contracts: Name Each Contracting Entity	Type of Entity: P=Public V=Private	Contract in place Y/N	Cities/ Counties Served	No. of Full Time EMS First responders under Your Direct Supervision	No. of Part time EMS First responders/Firemen under your Direct Supervision

# NAUTILUS INSURANCE COMPANY

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## *SIGNATURE SECTION AND OTHER INFORMATION*

**NOTE: Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.**

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

**APPLICABLE IN THE STATE OF NEW YORK:** ANY PERSON WHO KNOWINGLY AND WITH 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 CONTAINING 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 SUCH VIOLATION.

\_\_\_\_\_  
Signature and Title of Principal (must be owner, partner, or officer)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name and Title of Principal Signing Above

## NAUTILUS INSURANCE COMPANY

NOTICE TO COLORADO APPLICANTS: 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

NOTICE TO NEW MEXICO, PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS OF 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.

NOTICE TO APPLICANTS OF OKLAHOMA: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR DECEIVES ANY INSURER OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, IS GUILTY OF A FELONY AND IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE, MASSACHUSETTS, TENNESSEE, VIRGINIA, AND WASHINGTON 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 OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO APPLICANTS OF FLORIDA: 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 OF THE THIRD DEGREE.

NOTICE TO ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, AND RHODE ISLAND 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 MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY 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 OREGON 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 MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES.

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.