NPSecure®

Malpractice Insurance For Nurse Practitioners

For nearly 100 years, CM&F has partnered with the country's strongest insurers for the most comprehensive coverages available. This **Occurrence Form Insurance Policy** is underwritten by America's foremost healthcare malpractice insurer - The Medical Protective Company [MedPro], a member of the Warren Buffett/Berkshire Hathaway group of businesses. MedPro enjoys an A++ financial strength rating from the A. M. Best Company. With our combined resources and expertise, we have forged a commitment to support our clients with the challenges which they might face by providing sound protection - today, tomorrow and beyond.

Coverage Summary

COVERAGES	
Professional Liability	Included
Workplace/Premises Liability	Included
General Liability	Available
Good Samaritan	Included
Employment Practices Liability	Available
Assault Upon You	$25,000
First Aid	$15,000
Medical Payments	$25,000/$100,000
Deposition Fees	$10,000
License Defense	$25,000/$100,000
Sexual Misconduct	$25,000
Loss Of Earnings	$2,500 Per Day /$35,000 Aggregate
HIPAA Defense	$25,000
Biomedical Defense	$10,000

CM&F GROUP, INC®

For Fastest Coverage, Apply Online Today!

www.CMFGroup.com

Need Help? Have A Question About Coverage? Call Us At 1-800-221-4904 Or Email Us At info@cmfgroup.com

NURSE PRACTITIONERS ANNUAL RATE TABLES

ARKANSAS

FULL TIME PRACTICE RATES (MORE THAN 10 HOURS PER WEEK)

CLASS N1	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 574.00
$200,000 / $600,000	$ 619.00
$250,000 / $750,000	$ 637.00
$500,000 / $1,000,000	$ 691.00
$1,000,000 / $3,000,000	$ 861.00
$1,000,000 / $6,000,000	$ 897.00

CLASS N1	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 465.00
$200,000 / $600,000	$ 501.00
$250,000 / $750,000	$ 516.00
$500,000 / $1,000,000	$ 559.00
$1,000,000 / $3,000,000	$ 698.00
$1,000,000 / $6,000,000	$ 727.00

CLASS N2	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 812.00
$200,000 / $600,000	$ 875.00
$250,000 / $750,000	$ 901.00
$500,000 / $1,000,000	$ 977.00
$1,000,000 / $3,000,000	$ 1,218.00
$1,000,000 / $6,000,000	$ 1,269.00

CLASS N2	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 659.00
$200,000 / $600,000	$ 710.00
$250,000 / $750,000	$ 731.00
$500,000 / $1,000,000	$ 793.00
$1,000,000 / $3,000,000	$ 989.00
$1,000,000 / $6,000,000	$ 1,030.00

CLASS N3	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 1,050.00
$200,000 / $600,000	$ 1,132.00
$250,000 / $750,000	$ 1,164.00
$500,000 / $1,000,000	$ 1,263.00
$1,000,000 / $3,000,000	$ 1,575.00
$1,000,000 / $6,000,000	$ 1,641.00

CLASS N3	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 850.00
$200,000 / $600,000	$ 916.00
$250,000 / $750,000	$ 943.00
$500,000 / $1,000,000	$ 1,023.00
$1,000,000 / $3,000,000	$ 1,275.00
$1,000,000 / $6,000,000	$ 1,329.00

CLASS N4	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 1,289.00
$200,000 / $600,000	$ 1,390.00
$250,000 / $750,000	$ 1,430.00
$500,000 / $1,000,000	$ 1,551.00
$1,000,000 / $3,000,000	$ 1,934.00
$1,000,000 / $6,000,000	$ 2,015.00

CLASS N4	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 1,044.00
$200,000 / $600,000	$ 1,125.00
$250,000 / $750,000	$ 1,158.00
$500,000 / $1,000,000	$ 1,256.00
$1,000,000 / $3,000,000	$ 1,566.00
$1,000,000 / $6,000,000	$ 1,632.00

CLASS NS	FULL TIME
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 176.00
$200,000 / $600,000	$ 190.00
$250,000 / $750,000	$ 195.00
$500,000 / $1,000,000	$ 212.00
$1,000,000 / $3,000,000	$ 264.00
$1,000,000 / $6,000,000	$ 275.00

Nurse Practitioner Rating Classes

N1: Specializing in Dermatology, Geriatric, Women's Health Care, Oncology, Gynecology, or Correctional Facility < 10 hours/week

N2: Specializing in Psychiatric Care

N3: Specializing in Family Practice, Pediatric, School Nurse, Neonatal Care

N4: Specializing in Acute Critical Care, OB/GYN, Perinatal Care, Cosmetic/Aesthetic, Pain Management or Correctional Facility > 10 hours/week

NS: Students currently attending an accredited Nurse Practitioner Program

NURSE PRACTITIONERS ANNUAL RATE TABLES

ARKANSAS

PART TIME PRACTICE RATES (10 HOURS OR LESS PER WEEK)

CLASS N1	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 287.00
$200,000 / $600,000	$ 310.00
$250,000 / $750,000	$ 319.00
$500,000 / $1,000,000	$ 346.00
$1,000,000 / $3,000,000	$ 431.00
$1,000,000 / $6,000,000	$ 449.00

CLASS N1	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 233.00
$200,000 / $600,000	$ 251.00
$250,000 / $750,000	$ 258.00
$500,000 / $1,000,000	$ 280.00
$1,000,000 / $3,000,000	$ 349.00
$1,000,000 / $6,000,000	$ 364.00

CLASS N2	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 406.00
$200,000 / $600,000	$ 438.00
$250,000 / $750,000	$ 451.00
$500,000 / $1,000,000	$ 489.00
$1,000,000 / $3,000,000	$ 609.00
$1,000,000 / $6,000,000	$ 635.00

CLASS N2	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 330.00
$200,000 / $600,000	$ 355.00
$250,000 / $750,000	$ 366.00
$500,000 / $1,000,000	$ 397.00
$1,000,000 / $3,000,000	$ 495.00
$1,000,000 / $6,000,000	$ 515.00

CLASS N3	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 525.00
$200,000 / $600,000	$ 566.00
$250,000 / $750,000	$ 582.00
$500,000 / $1,000,000	$ 632.00
$1,000,000 / $3,000,000	$ 788.00
$1,000,000 / $6,000,000	$ 821.00

CLASS N3	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 425.00
$200,000 / $600,000	$ 458.00
$250,000 / $750,000	$ 472.00
$500,000 / $1,000,000	$ 512.00
$1,000,000 / $3,000,000	$ 638.00
$1,000,000 / $6,000,000	$ 665.00

CLASS N4	SELF EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 645.00
$200,000 / $600,000	$ 695.00
$250,000 / $750,000	$ 715.00
$500,000 / $1,000,000	$ 776.00
$1,000,000 / $3,000,000	$ 967.00
$1,000,000 / $6,000,000	$ 1,008.00

CLASS N4	EMPLOYED
LIMIT	OCCURRENCE
$100,000 / $300,000	$ 522.00
$200,000 / $600,000	$ 563.00
$250,000 / $750,000	$ 579.00
$500,000 / $1,000,000	$ 628.00
$1,000,000 / $3,000,000	$ 783.00
$1,000,000 / $6,000,000	$ 816.00

Nurse Practitioner Rating Classes

N1: Specializing in Dermatology, Geriatric, Women's Health Care, Oncology, Gynecology, or Correctional Facility < 10 hours/week

N2: Specializing in Psychiatric Care

N3: Specializing in Family Practice, Pediatric, School Nurse, Neonatal Care

N4: Specializing in Acute Critical Care, OB/GYN, Perinatal Care, Cosmetic/Aesthetic, Pain Management or Correctional Facility > 10 hours/week

NPSecure®
Malpractice Insurance For Nurse Practitioners

1) Please print a copy of this application to your desktop printer.
2) Complete this hard copy by hand, answering all questions
3) Sign, date and either:
   a. Mail your completed application providing your credit card information OR with check payable to:
   CM&F Group, Inc., 99 Hudson Street, 12th Floor, New York, NY 10013
   OR
   b. Fax your signed and completed application providing your credit card information (per the application) to CM&F Group, Inc. at (646) 390.5163
4) Once your application is processed & approved, your policy will be mailed within 5-7 business days. Your payment -- whether by check or credit card -- will NOT be processed until your coverage has been approved.

Fax or Mail Completed Application To:
CM&F Group, Inc.
99 Hudson Street, 12th Floor
New York, New York 10013-2815
(212)233-8911 (800)221-4904
Fax (646)390.5163 np@cmfgroup.com

If previously covered with Medical Protective, please enter the policy number _____

THE MEDICAL PROTECTIVE COMPANY

(a Stock Company)

HEALTHCARE PROFESSIONAL - PROFESSIONAL LIABILITY INSURANCE APPLICATION - NP

I. General Information

Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

A. _____
First Name Middle Initial Last Name

_____ _____ _____ / _____ / _____ _____ _____
Degree (DNP/MA) Suffix Date of Birth MM/DD/YYYY Professional License Number Graduation Year

_____ _____ _____
Street Address Apartment/Suite # City

_____ _____ _____ _____ _____
County State Zip Code State of Practice National Provider Identifier # (Optional)

_____-_____-_____ _____-_____-_____ _____-_____-_____
Business Phone Business Fax Residence/Cell Phone

E-mail Address: _____

B. Requested Effective Date: _____ /_____ /_____
MM DD YYYY

II. Coverage Information

**Please note that requested policy types may not be available in all states.*

A. Coverage Desired:

___ Occurrence coverage
___ Claims-Made coverage without Prior Acts coverage **PLEASE CALL FOR MORE INFORMATION**
___ Claims-Made coverage with Prior Acts coverage **PLEASE CALL FOR MORE INFORMATION**
___ Convertible Claims-Made coverage **PLEASE CALL FOR MORE INFORMATION**

B. Retroactive date shown on my current Claims-Made policy is: ____ / _____ / _____
(This date is not a requirement for Occurrence or Claims-Made without Prior acts policies.) MM DD YYYY

C. If "Occurrence" or "Claims-Made coverage without Prior Acts coverage" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

__ An extended reporting endorsement (tail coverage) has been purchased.
__ An extended reporting endorsement has not and will not be purchased.

* Please be advised that if you do not purchase tail coverage (an extended reporting endorsement) from your current insurer where you are insured under a Claims-Made policy, this will result in an uninsured exposure for any claims which may arise as a result of professional services rendered or which should have been rendered while insured by your current insurer's

policy. If you do not purchase tail coverage from your current insurer, understand that the policy for which you are applying with The Medical Protective Company, if offered, will not provide prior acts coverage.

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, or made and reported during the (60) day automatic extended reporting period in accordance with Ark. Code Ann. §23-79-306(2) or any optional extended reporting period issued in accordance with Ark. Code Ann. §23-79-306(3A), for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence.

D. Desired Limits:

** Please note that requested limits options may not be available in your state.*

__ $100,000/$300,000 __ $200,000/$600,000 __ $250,000/$750,00
__$500,000/$1,000,000 __ $1,000,000/$3,000,000 __ $1,000,000/$6,000,00
__$2,000,000/$6,000,000

__ **VA Only:** The limits of insurance for Insureds practicing in Virginia will equal the annual damages cap, as set out in VA Code Ann.§ 8.01-581.15 as amended, based upon the expiration date of the policy to which this application may become attached.

E. Are you an Indiana resident electing to participate in the Indiana Patient Compensation Fund? __ Yes __ No
If yes, coverage provided will have limits of $250,000/$750,000.

F. Are you a Louisiana resident electing to participate in the Louisiana Patient Compensation Fund? __ Yes __ No
If yes, coverage provided will have limits of $100,000/$300,000.

G. If in Maryland, do you want to purchase administrative hearing coverage? __ Yes __ No
Administrative Hearing Expense Coverage Option: $25,000 each limit/$100,000 aggregate limit.
Defense arising out of Disciplinary, Licensure or similar Administrative Proceedings, arising from your professional services as a Healthcare Professional to a patient may be purchased for an additional premium.

III. Practice Information

A. Please indicate your Nurse Practitioner Rating Class: (Please select all that are applicable. At least one must be selected.)

N1: ☐ Dermatology ☐ Geriatric ☐ Women's Health Care ☐ Oncology ☐ Gynecology
☐ Correctional Facility < 10 hours/week

N2: ☐ Psychiatric Care

N3: ☐ Family Practice ☐ Pediatric ☐ School Nurse ☐ Neonatal Care

N4: ☐ Acute Critical Care ☐ OB/GYN ☐ Perinatal Care ☐ Cosmetic/Aesthetic ☐ Pain Management
☐ Correctional Facility > 10 Hours / Week

NS: Students currently attending an accredited Nurse Practitioner Program

*** *I understand that if I am a Nurse Anesthetist or Certified Nurse Midwife, I am not covered by this policy*.**

B. If your specialty is OB/GYN, are you responsible for the labor or delivery of a fetus? __ Yes __ No __ N/A

C. Do you perform any major invasive surgical procedures? __ Yes __ No

If yes, please give a general description: _____

D. As a Nurse Practitioner I practice as: ___ Employee (W2 & not owner) ___ Self-Employed (File 1099 Tax Form)

E. Indicate the estimated average number of hours you practice per week. _____

F. Is your professional designation/certification currently valid? __ Yes __ No

Please provide date of most recent certification: ___ / ___ / _____
MM DD YYYY

G. Highest level of education: __ **Masters (MS)** __ **Doctorate (DNP)** __ **Licensed Nurse Midwife**

H. Have you completed training/education courses in addition to the level required for licensing/certification?

If yes, please provide details. _____

I. If you are a student, what is the anticipated date of graduation? ___ /___ /_____
MM DD YYYY

J. Are you a member of a Professional Association(s)? __ Yes __ No

If yes, please list membership affiliation(s) _____

K. Have you completed a risk management education course within the last (12) months? __ Yes __ No

IV. Additional Practice Information

A. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses? __ Yes __ No

If yes, please attach a separate sheet with full particulars including date(s).

B. Have you ever had your hospital privileges, DEA license, healthcare license or reimbursement privileges, refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? __ Yes __ No

If yes, please attach a separate sheet with full particulars including date(s).

C. Has any professional liability insurance company ever declined, refused, canceled or non-renewed your coverage? NOTE: MISSOURI AND CALIFORNIA RESIDENTS DO <u>NOT</u> RESPOND. __ Yes __ No

If yes, please indicate the date(s) and explain: Date ____ /_____ _____
MM YYYY

D. Have you ever been accused of sexual misconduct of any kind? __ Yes __ No

If yes, please indicate the date(s) and explain: Date ___ /_____ _____
MM YYYY

E. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction to alcohol, narcotics or other controlled substances, etc).
__ Yes __ No

* If yes, please complete Medical Condition Supplement

V. Loss Information

Please complete the Loss Information Supplement for each written request, incident, claim or suit that has NOT been covered by a Medical Protective policy.

Report professional liability and malpractice-related matters, including but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim, or suit, received a written request for treatment records arising out of the rendering or failure to render professional services, or related to any other coverage you are requesting from Medical Protective (e.g. CGL, EPLI, etc.)**?** __ Yes __ No

If yes, how many? _____

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? __ Yes __ No

This includes, but it is not limited to, the following:

◊ Amputation ◊ Permanent Neurological Injury ◊ Loss of Major Organ Function ◊ Death ◊ Loss of Vision.

If yes, how many? _____

C. In the last 12 months, have you received a written request from an attorney for treatment records concerning any current or former patient(s) which might reasonably result in a claim or suit against you? __ Yes __ No

If yes, how many? _____

VI. Professional Liability Coverage

A. Please list your prior professional liability insurance, if any.

Insurance Carrier	Coverage Type (Occurrence or Claims-Made)	Policy Number	Limits	Effective Date(s)	Retro Date

VII. Important Notice – Representations, Authorizations, Releases and Notices

MANDATORY: ALL ARKANSAS APPLICANTS must read the following:
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.

VIII. Notes and Agreements

I further acknowledge that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "**Attachments**") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I or any applicant agree that this application, and any **Attachments**, shall be the bases of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in professional specialty, affiliation or working arrangement with any other healthcare provider, facility, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the company has: (1) received my completed application; (2) my application has been accepted by the Company; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer, credit card payment or money order, it shall not be considered as "received" by the company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

_____ Date Signed: ____ / ____ / _____
Applicant's Signature MM DD YYYY

_____
Print Name

Agent Name & License Number (if applicable): _____

PREMIUM PAYMENT OPTIONS

PREPAYMENT REQUIRED

☐ Check or money order enclosed. ☐ Charge premium to credit card.
I authorize CM&F Group, Inc. to charge the premium to my: ☐ VISA ☐ MASTERCARD ☐ Discover

Credit Card Account Number:_____ Expiration Month and Year: ____ / _____
Print name exactly as it appears on card:_____

THIRD PARTY CREDIT CARD AUTHORIZATION Please complete the following (if payer other than applicant):

CHARGE TO: ☐ VISA ☐ MASTERCARD ☐ Discover

Credit Card Account Number:_____ Expiration Month and Year: ____ / _____
Card Member Name (Print):_____
Signature:_____ Date Signed:_____

MAIL OR FAX COMPLETED APPLICATION & PAYMENT INFORMATION TO:

CM&F Group, Inc.
99 Hudson Street, 12th Floor, New York, NY 10013-2815
212.233.8911 1.800.221.4904 FAX: 646.390.5163 np@cmfgroup.com

THE MEDICAL PROTECTIVE COMPANY APPLICANT NAME: _____

MULTI-SPECIALTY HEALTHCARE PROFESSIONAL

LOSS INFORMATION SUPPLEMENT

Please complete the following information for each applicant involved in each claim or incident. Please make copies if additional forms are needed for multiple claims or incidents and/or each applicant.

Note: Additional documentation may be requested at The Medical Protective Company's discretion.

A. Is the matter related to A, B or C from the Loss Information section? (Check only one.)

- □ **A.** Current or prior claim.
- □ **B.** Complication, incident, or adverse outcome.
- □ **C.** Written request for records.

B. Is the matter identified in the Loss Information section related to (Check only one)**:**

- □ Professional Liability
- □ Other Commercial Liability, i.e. General Liability, EPLI, Cyber, etc. (please describe): _____

C. Patient/Claimant Information:

_____ _____ _____
Last Name First Name Age

D. Date of treatment and/or surgery which led, or could lead, to allegations against you: _____ / _____ (MM/YYYY)

E. Date of notice received, if applicable: _____ / _____ (MM/YYYY)

F. Has this matter been reported to your current or former insurer? □ Yes □ No

If Yes, date reported to your current or former insurer: _____ / _____ (MM/YYYY)

Current or former insurer name: _____

If No, please explain: _____

G. Name of all other doctor(s), hospital(s), surgery center(s) or healthcare provider(s), if any, involved: _____

_____

H. Current status: □ Open □ Closed

If open, indicate dollar value established by insurer: $ _____

If closed, date of closing: _____ / _____ (MM/YYYY)

Was a payment made? □ Yes □ No

1. If Yes, did you consent to the settlement? □ Yes □ No
2. Total amount of settlement or award: $ _____
3. Total amount of settlement or award paid on your behalf: $ _____

I. Nature of allegations or potential allegations:

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

J. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

_____

_____

K. What steps or procedures have you adopted to prevent a similar claim? Please explain:

_____

_____

Applicant's Name: _____

HEALTHCARE PROFESSIONAL LIABILITY INSURANCE APPLICATION

Assignment of Cancellation Rights and Premium Refund Supplemental Application

Would you like to assign an employer or named third party the right to cancel your policy and receive any premium refund? _____ Yes _____ No

If yes, please sign below:

By my signature, I assign to the following employer or named third party (include name and address), the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all premium refund correspondence be sent to me at the last address of record. This assignment may be revoked by me at any future time by faxing a written notice to CM&F Group at 212-233-8919 or sending written notice to The Medical Protective Company Program Administrator, CM&F Group, Inc. 99 Hudson Street, 12th Floor, New York, NY 10013-2815.

_____

Name of Employer or Third Party

_____

Street Address

_____ _____ _____

City State Zip Code

(_____) _____

Phone #

_____

Signature of Applicant

_____

Date