APPLICATION FOR NURSE ANESTHETISTS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.
If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: _____

   (ii) Professional Degree: _____

   (b) Principal business address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) (i) Phone: _____ (ii) Fax: _____

   (iii) E-Mail Address: _____ (iv) Website Address: _____

   (d) (i) Date of Birth (MM/DD/YYYY): _____ (ii) Place of Birth: _____

2. (a) Requested Effective Date: _____ (b) Requested Retroactive Date: _____

3. Are you a U.S. citizen? [ ] Yes [ ] No
   If No, what is your status in the U.S. and current citizenship? _____

4. (a) Type of practice for which coverage is requested:

   [ ] solo practitioner (unincorporated)
   [ ] solo practitioner (incorporated)*
   [ ] employee of _____
   [ ] employee of locum tenens company
   [ ] independent contractor of _____
   [ ] free-lance locum tenens
   [ ] independent contractor of locum tenens company

   * Specify name of entity: _____

   (b) The practice for which coverage is requested is:

   [ ] full-time [ ] part-time [ ] "moonlighting"

   If the practice for which coverage is requested is part-time or "moonlighting" answer the following:

   (i) Provide the name and address of your full-time position and number of weekly hours not including on-call.

   _____

   (ii) Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice.

5. Do you own a locum tenens company? [ ] Yes [ ] No

   If Yes, are you requesting coverage for this company? [ ] Yes [ ] No

   (i) If No, attach a Certificate of Insurance for Professional Liability Insurance for locum tenens company.

   (ii) If Yes, complete our Locum Tenens and Contract Staffing Application (SM6210).

6. Do you work for and/or accept work assignments or placements from any locum tenens company? [ ] Yes [ ] No
   If Yes, complete the following for each company:

Name of Company	Address	Employee or Independent Contractor	No. of Hrs. Each Month	Is Prof. Liab. Insurance Provided to You? (Yes/No)*

   * If Yes, attach a copy of your Certificate of Insurance.
   If No, are you requesting coverage for this activity? [ ] Yes [ ] No

7. Are you a free-lance locum tenens not placed by or associated with any locum tenens company? [ ] Yes [ ] No

8. Are you currently in active military service? [ ] Yes [ ] No

9. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

10. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? [ ] Yes [ ] No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer. _____

Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

II. EDUCATION AND TRAINING

1. Provide the following information:

	Name of Institution	City	State	Date Completed
Nursing School				
Graduate School				

2. Provide a detailed summary of where you have practiced your profession since completing your training: _____

3. Are you a member of any professional societies? [ ] Yes [ ] No
If Yes, provide information regarding your membership(s). _____

III. SCOPE OF PRACTICE

1. (a) Principal practice location for which coverage is requested:

_____
(Practice Name) (Street)

_____
(City) (State) (Zip)

(b) Provide the number of weekly hours for your principal practice location (exclude on-call hours). _____

(c) Your principal practice location is a(n):

[ ] Hospital [ ] Ambulatory Surgery Center [ ] Professional Office with Specialty

2. (a) Secondary practice location for which coverage is requested. (If none, check here [ ])

_____
(Practice Name) (Street)

_____
(City) (State) (Zip)

(b) Provide the number of weekly hours for your secondary practice location (exclude on-call hours). _____

(c) Your secondary practice location is a(n):

[ ] Hospital [ ] Ambulatory Surgery Center [ ] Professional Office with Specialty

3. Are you supervised by an Anesthesiologist at each location for which coverage is requested? [ ] Yes [ ] No
If Yes, is 100% of your practice supervised by an Anesthesiologist? [ ] Yes [ ] No
If No, what percentage of your practice is supervised by the following:

___% Another CRNA ___% Dentist/Oral Surgeon ___% Podiatrist

___% Anesthesiologist ___% Ophthalmologist ___% Other Physician _____

___% Bariatric Surgeon ___% Plastic/Cosmetic Surgeon

4. Indicate the approximate percentages of your patients for which coverage is requested:

___% Bariatric Surgery ___% Dental/Oral Surgery ___% Obstetrical ___% Ophthalmological

___% Pediatric ___% Podiatric ___% Plastic or Other Cosmetic Surgery

___% Non-Surgical Pain Management (describe)_____

___% Research or Experimental (describe)_____

___% Other Surgery or Experimental (describe)_____

5. During administration of all anesthetics, do you use a pulse oximeter monitor? [ ] Yes [ ] No
   If No, explain._____

6. During all anesthetics,

   (a) Is an electrocardiogram continuously displayed? [ ] Yes [ ] No
   If No, explain._____

   (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? _____

7. During all general anesthesia, do you use an end tidal CO2 monitor? [ ] Yes [ ] No
   If No, explain._____

8. During all general anesthesia using an anesthesia machine, do you:

   (a) Use an oxygen analyzer with a low concentration limit alarm? [ ] Yes [ ] No
   If No, explain._____

   (b) Test proper functioning of alarms prior to each use? [ ] Yes [ ] No
   If No, explain._____

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

   (a) Use a device equipped with a full set of safety alarms? [ ] Yes [ ] No
   If No, explain._____

   (b) Test proper functioning of alarms prior to each use? [ ] Yes [ ] No
   If No, explain._____

10. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? [ ] Yes [ ] No
    If No, explain._____

11. Provide the following:

	Weekly	Annually
(a) Average number of patients you saw during the last 12 months for all jobs.	_____	_____
(b) Estimated number of patients you will see during the next 12 months for all jobs.	_____	_____
(c) Estimated number of patients you will see during the next 12 months for all jobs for which coverage is requested.	_____	_____

12. Provide the following (exclude on-call hours):

    (a) Your average number of weekly practice hours for all jobs. _____

    (b) Your average number of weekly practice hours for all jobs for which coverage is requested? _____

13. What is your gross annual revenue from your practice for this year? $_____ Estimate for next year? $_____

14. Do you employ anyone? [ ] Yes [ ] No
    If Yes,

    (a) Indicate by profession the number of individuals you employ:

    ___ Nurse Anesthetists ___ Other Professionals (describe) _____

    Provide a detailed explanation of the responsibilities for each profession, including the extent supervised.

    _____

    (b) Are all of the above individuals licensed in accordance with applicable state and federal regulations? [ ] Yes [ ] No

    If No, attach as detailed explanation.

(c) Attach protocols and Certificate of Insurance for Professional Liability Insurance for all individuals you employ.

15. Do you supervise anyone other than your own employees? [ ] Yes [ ] No
If Yes, indicate by profession the number of individuals you supervise:

___ Nurse Anesthetists ___ Other Professionals (describe) _____

Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. _____

_____

16. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date*

* Attach a copy of the Declarations page from your current policy.

17. Do you currently participate in any state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? [ ] Yes [ ] No
If Yes, identify._____

18. Do you anticipate any changes in your practice in the next year? [ ] Yes [ ] No
If Yes, attach a detailed explanation.

IV. CLAIMS AND HISTORY

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? [ ] Yes [ ] No
If Yes, how many? _____Complete a Markel Shand, Inc. Supplemental Claim form for each one.

2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? [ ] Yes [ ] No
If Yes, how many? _____Complete a Markel Shand, Inc. Supplemental Claim form for each one.

3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? [ ] Yes [ ] No
If Yes, how many? _____ Complete a Markel Shand, Inc. Supplemental Claim form for each one.

4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by an employer, contractor, hospital, managed care organization or other organization to deny, limit, suspend, non-renew or revoke your privileges, employment or ability to practice? [ ] Yes [ ] No
If Yes, attach complete copies of all official documents issued by the organization which address the allegations, the findings, and the outcome.

5. Has your license to practice nursing or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? [ ] Yes [ ] No
If Yes, attach complete copies of all documents issued by the licensing authorities involved in each investigation, restriction, suspension, revocation, probation or termination.

6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? [ ] Yes [ ] No
If Yes, attach complete copies of all documents issued by the licensing authorities involved in each investigation.

7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? [ ] Yes [ ] No
   If Yes, attach a detailed summary of the circumstances, charges, jurisdiction, dates and current status/ outcome of each, and complete copies of any documents issued by police or judicial authorities which confirm your current status or outcome.

8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? [ ] Yes [ ] No
   If Yes, attach a detailed summary of your diagnosis, treatment dates and locations, treating physicians, current status and copies of any licensing board or hospital documents related to your status.

9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? [ ] Yes [ ] No
   If Yes, attach a detailed summary of your status.

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

Markel Shand, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which Markel Shand, Inc. receives notice is on file with Markel Shand, Inc. and is considered physically attached to and part of the of the policy if issued. Markel Shand, Inc. and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Markel Shand, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Markel Shand, Inc. or the Company, Ten Parkway North, Deerfield, Illinois 60015.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant	Title
Signature of Applicant	Date

Notice to 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 the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS

BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Markel Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: