

## QUESTIONNAIRE: MEDICAL PROFESSIONALS LIABILITY - IN

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Requested Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### ELIGIBLE PROFESSIONAL DESCRIPTIONS

- |   |   |   |
|---|---|---|
| Audiologist <input type="checkbox"/>                                      | Instructor/Teacher <input type="checkbox"/>                           | Physical Therapist/<br>Physiotherapist or<br>Assistant <input type="checkbox"/> |
| Corrective Therapist <input type="checkbox"/>                             | Licensed Practical Nurse <input type="checkbox"/>                     | Prosthetist <input type="checkbox"/>  |
| Dental Assistant <input type="checkbox"/>                                 | Medical Assistant <input type="checkbox"/>                            | Recreational Therapist <input type="checkbox"/>                                 |
| Day Care Center Nurse <input type="checkbox"/>                            | Medical Record Technician <input type="checkbox"/>                    | Registered Nurse <input type="checkbox"/>                                       |
| Dental Hygienist <input type="checkbox"/>                                 | Medical Technologist <input type="checkbox"/>                         | Respiratory Therapist <input type="checkbox"/>                                  |
| Dialysis Technician<br>(Maximum limit \$100,000) <input type="checkbox"/> | Nurse Aide <input type="checkbox"/>                                   | Speech Pathologist <input type="checkbox"/>                                     |
| Dietician <input type="checkbox"/>  | Nurse Assistant <input type="checkbox"/>                              | School Nurse/Camp Nurse <input type="checkbox"/>                                |
| EEG Technician <input type="checkbox"/>                                   | Nurse Practitioner <input type="checkbox"/>                           | Ultrasound Technologist <input type="checkbox"/>                                |
| EKG Technician <input type="checkbox"/>                                   | Occupational Therapist/<br>Massage Therapist <input type="checkbox"/> |   |
| Inhalation Therapist <input type="checkbox"/>                             | Ophthalmic Assistant <input type="checkbox"/>                         |   |

PROFESSIONAL			PERSONAL		MEDICAL PAYMENTS		PREMIUMS
Each Person	Each Occurrence	Aggregate Policy Pd	Each Person	Aggregate Policy Pd	Each Person	Each Accident	Annual
\$1,000,000	\$1,000,000	\$1,000,000	\$100,000	\$100,000	\$1,000	\$10,000	\$150.00
500,000	500,000	500,000	100,000	100,000	1,000	10,000	110.00
250,000	250,000	750,000	100,000	300,000	1,000	10,000	77.00
300,000	300,000	300,000	100,000	100,000	1,000	10,000	75.00
100,000	100,000	100,000	100,000	100,000	1,000	10,000	65.00
STUDENT APPLICANT							
\$100,000	\$100,000	\$100,000	\$100,000	\$100,000	\$1,000	\$10,000	\$50.00
50,000	50,000	50,000	50,000	50,000	1,000	10,000	45.00

Agent's Name: Surplus Insurance Brokers Agency Inc Agency Code: 07351  
 Agent's Address: P O Box 749, South Bend IN 46624-0749

### STATE OF INDIANA MEDICAL MALPRACTICE ACT (OPTIONAL ADDITIONAL COVERAGE FOR 250/250/750 LIMITS)

The state of Indiana has authorized Capitol Indemnity Corporation to offer insurance via the Indiana Medical Malpractice Act.

I  Accept/ I  Reject the STATE OF INDIANA MEDICAL MALPRACTICE ACT optional coverage.

Applicant Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Premium for the Indiana Medical Malpractice Act is \$100 in addition to Capitol Indemnity Corporation's premium (\$177 total). Medical Malpractice premium is paid to the State of Indiana Medical Malpractice Fund, is fully earned at the beginning of the policy period, and will not be refunded if the policy is cancelled

**PLEASE ENCLOSE TOTAL PAYMENT AND MAIL TO THE AGENT SHOWN ABOVE.**

**Please answer all of the following questions completely.**

- **Coverage is subject to review and approval by the home office underwriting department.**

1. If Applicant is a student, state the date or expected date of graduation and/or accreditation. (Maximum Professional/Personal Limits for Students - \$100,000) \_\_\_\_\_
2. State your professional license or registration number assigned by state and/or other regulatory body. \_\_\_\_\_
3. Description of professional duties: \_\_\_\_\_
4. Are you working under written or standing doctors orders?  Yes  No
5. Location of employment:
 

Doctor's Office	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Clinic	<input type="checkbox"/>	Nursing Home	<input type="checkbox"/>	_____	
Dental Office	<input type="checkbox"/>	Private Home(s)	<input type="checkbox"/>	_____	
6. Number of years in practice: \_\_\_\_\_
7. Do you supervise any other nurses or health care professionals?  Yes  No  
 If yes, describe: \_\_\_\_\_
8. Are you a proprietor or officer of any medical establishment?  Yes  No  
 If yes, describe: \_\_\_\_\_
9. Are there past or pending professional malpractice or personal liability claims against you?  
 If yes, describe: \_\_\_\_\_
10. Has any insurer during the past three years cancelled your coverage?  Yes  No  
 If yes, describe: \_\_\_\_\_

**IMPORTANT NOTICE**

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY. Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.** (As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

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Applicant Signature	Title	Date
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