



Locum Tenens Application EMS Medical Directors Application Checklist

- Locum Tenens coverage is only available for a physician who is temporarily substituting for an EMS Medical Director insured for specific dates during a policy year.
- An application for Locum Tenens coverage must be submitted at least one week prior to the proposed effective date of coverage.
- Both the EMS Medical Director Named Insured and Locum Tenens must sign the application.
- Attach the following to this application:
 - Copy of Medical License

Complete ALL areas of the application, indicating “N/A” when necessary.

Return the completed application to:

Lapre Scali & Company Insurance Services, LLC
c/o Thomas James
6200 Coors Blvd NW #K-3
Albuquerque NM 87120
Phone: 1-505-899-2068 or 1-866-577-7833
Fax: 1-505-217-0570
Email: tjames@laprescali.com



APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

Emergency Medical Services – Medical Directors Locum Tenens

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

PLEASE PRINT OR TYPE LEGIBLY IN INK

Part One: Named Insured Information

1. Name: _____
First Last Middle Initial
2. Policy/Certificate Number: _____ Medical Specialty: _____

Part Two: Locum Tenens Information

1. Name: _____
First Last Middle Initial
2. MD DO
3. Social Security #: _____ Date of Birth: _____
4. Medical License Number: _____ Medical Specialty: _____
5. Primary Address: _____
Street

- City _____ State _____ Zip Code _____
6. Office Phone: _____ Fax: _____
7. Home Phone: _____ Mobile / Other: _____
8. Email Address: _____ Web Address: _____

9. Does applicant carry professional liability insurance that covers this locum tenens activity? Yes No
 If "Yes," name of insurance company: _____

10. Is the applicant an intern, resident or enrollee in a medical training fellowship program? Yes No



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a W.R. Berkley Company

If "Yes," which one? _____

11. Is the applicant a licensed physician in Good Standing? Provide copies of all licenses. Yes No
 11a. If "Yes," where? _____
 11b. If "No," please explain: _____
12. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation ever been invoked? Yes No
13. Has your narcotic or medical license ever been suspended, placed on probation, restricted, revoked, or voluntarily surrendered? Yes No
14. Have you ever been denied a medical license or been denied certification by a specialty board? Yes No
15. Have you ever been the subject of disciplinary proceedings; reprimanded by a governmental agency; convicted or currently under investigation for a crime other than a traffic offense? Yes No
16. Have any claims or suits been made or brought against you in the past 10 years? Yes No
 If "Yes," please describe in the remarks section.
17. Do you have knowledge of any claim or circumstance that might give rise to a claim being made against you? If yes, please describe in the remarks section. Yes No
18. Please check and specify locum tenens coverage desired:
- Single date (e.g., July 1) _____
- Two or more single dates (e.g., July 1, July 20) _____
- Continuous coverage period (e.g., July 1 – July 20) _____

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



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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.

FRAUD WARNING: 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.

FRAUD WARNING (Applicable in Tennessee and Washington): 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.

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



EMERGENCY MEDICAL SERVICES MEDICAL DIRECTORS PROFESSIONAL
LIABILITY CLAIM/CIRCUMSTANCE/ADMINISTRATIVE HEARINGS
SUPPLEMENT

APPLICANTS INSTRUCTIONS:

- Complete one form for each claim or circumstance reported in the last ten (10) years involving you or your medical license.
If space is insufficient to answer any question, use the reverse side or attach a separate sheet.
Answer all questions.

(PLEASE TYPE OR PRINT)

1. Name(s) of individual(s) in the company named in the claim: _____

2. Name of claimant: _____

3. To what insurance company did you report this claim or incident? _____

3a. Date of alleged error: _____

3b. Date reported: _____

3b. Date first notice received: _____

4. Present status of claim (check one): [] in suit [] open circumstance [] closed

4a. If closed:

i. Total damages paid: \$ _____

ii. What is your percentage of the total settlement of all parties involved in this claim? _____ %

Total defense costs paid (including any deductible paid), if known:

\$ _____

Indicate whether: [] court judgment [] out of court settlement.

4b. If in suit or open: (Complete if known)

Amount asked in summons: \$ _____

Claimant's settlement demand: \$ _____

Defendant's offer for settlement: \$ _____

Insurer's loss reserve*: \$ _____

Defense costs paid to date: \$ _____

Your deductible that will apply to this claim: \$ _____

5. Description of claim (provide enough information to allow evaluation and attach a separate page if additional space is required). Alleged act, error or omission upon which claimant bases claim:

Signature of Employee

Date



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Print Name