



Lewis and Clark LTC Risk Retention Group, Inc.

Application for the Sophia Palmer product

First Name _____

Last Name _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____

Email Address _____

Date of Birth _____

Professional State License Number _____

1. Has your licensed ever been suspended or revoked? Have you ever been the subject of an ethics investigation by a state or professional licensing agency? Yes No
If yes please attach a separate document with your explanation

2. Have you ever been treated for substance abuse? Yes No
If yes please attach a separate document with your explanation

3. Have you ever had a claim made against you or do you currently have reason to believe a claim might be made against you? Yes No
If yes please attach a separate document with your explanation

4. Has your professional liability insurance ever been cancelled or non-renewed? Yes No
If yes please attach a separate document with your explanation

I am a/an

Aide	<input type="checkbox"/>	Licensed Practical Nurse	<input type="checkbox"/>
Licensed Vocational Nurse	<input type="checkbox"/>	Registered Nurse	<input type="checkbox"/>
Certified Nurse Specialist	<input type="checkbox"/>	Physicians Assistant	<input type="checkbox"/>
Nurse Practitioner/Advanced Practice Nurse	<input type="checkbox"/>	Certified Nurse Assistant	<input type="checkbox"/>
Nurse Midwife	<input type="checkbox"/>	Nurse Anesthetist	<input type="checkbox"/>

If you are a Registered Nurse or a Certified Nurse Specialist which area do you primarily work in?

Obstetrics First Assist Other

If you are a Physicians Assistant, Nurse Practitioner, or an Advanced Practice Nurse which area do you primarily work in?

Obstetrics/Womens Health Psychiatry Pediatrics Surgical Other
Family Planning/Gyn Aesthetics Family Geriatrics Acute/Critical Care

If you are a Nurse Midwife

Do you work under the auspices of an Obstetrician who carries Professional Liability Limits of at least \$250,000/\$750,000? **OR** Is your Obstetrician board certified with hospital privileges? Yes No

Do you deliver exclusively in a hospital or other institutional setting? Yes No

Are you ACNM Certified? Yes No

Policy and Coverage Information

1. What coverage do you desire? Claims Made Occurrence
2. What limits do you desire? \$100,000/\$300,000 \$250,000/\$750,000 Other Limits
3. Desired policy effective date? _____/_____/_____
4. Do you currently have professional liability coverage? Yes No
5. If you do have coverage what is the expiration date of the policy? _____/_____/_____
6. If you currently have professional liability coverage is it: Claims Made Occurrence
7. If your current coverage is Claims Made what is the retro date of the policy? _____/_____/_____
8. For Claims Made expiring coverage, do you want prior acts coverage? Yes No
9. How many hours a week do you work in a medical professional capacity?
10. Are any of these hours covered by other insurance? Yes No How many?
11. Are you a member of any association or organization? Yes No Which ones?

NOTICE TO APPLICANTS: "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 IN THE THIRD DEGREE."

The electronic signature will be held with the two pieces of information listed below.

_____Eye Color _____Mother Maiden Name

I understand that by checking the box below that I am attesting that I have read the Subscription Agreement and Investor letter.

I Agree

_____ Print your name

_____ Signature

_____ Date