



## MedEdge for Physician Assistants

MedEdge is the most comprehensive medical professional liability solution for Physician Assistants. Created by the insurance experts at NIP Programs with the specific needs of a Physician Assistant in mind, MedEdge is a customized insurance solution that includes multiple coverages and enhanced protection. Extreme Service, Superior Protection, Great Rates and Elite Experience. That's the MedEdge promise.

### We Go Beyond Insurance.

- Personal Advocate.
  - MedEdge is your own personal advocate, fighting to protect you, your interests and your career.
  - MedEdge protects you at ALL times, with your own coverage and your own dedicated policy limits.
  - We work to reduce risk for you. MedEdge insureds have a robust library of patient safety and risk management materials, guides and tools.
  - Our risk management team is an extension of your staff and we are available 24/7 to help you when you need it.
  - We keep you informed on new regulations, emerging trends and provide valuable tools to lower your risk profile and premiums over time.
- Defense.
  - We vigorously protect and defend the reputation and livelihood of our insureds.
  - We understand what a malpractice claim means to a Physician Assistant, how deeply it affects you not just professionally, but personally as well.
  - Our defense never rests. In the event a claim is leveled against you, our claims experts will be ready to marshal every resource necessary to resolve it. You can count on MedEdge from initial notice to final resolution.
- Rewards.
  - We reward you with discounts for your safe track record and commitment to superior patient care.

Our mission is simple: *To quickly, easily, effectively offer exceptional coverage and risk management products at a competitive price.*

### Submission:

**To receive a premium quotation, please complete the attached application. Be sure to complete all fields; if a question does not apply, "Not applicable" or "N/A" should be indicated.**

**Email the completed application to us at [NIProSub@nipgroup.com](mailto:NIProSub@nipgroup.com) or fax to (732) 791-1646.**

For more information, contact:

Israel Notoma  
inotoma@nipgroup.com  
(800) 446-7647 x363

**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA**  
 2595 Interstate Drive, Suite 103, Harrisburg, PA 17110  
**ADMINISTRATIVE OFFICES: 175 Water Street, New York, NY 10038**  
 (A Capital Stock Insurance Company)

**SCHOOL PROFESSIONAL LIABILITY PLUS APPLICATION**

If Claims-Made coverage is chosen, please note the following: **NOTICE: COVERAGE IS LIMITED TO LIABILITY FOR CLAIMS FIRST MADE AGAINST YOU DURING THE POLICY PERIOD OR AN EXTENDED REPORTING PERIOD, IF APPLICABLE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE.**

**INSTRUCTIONS**

- 1) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Applicable).
- 2) If you need more space for responses, continue on a separate sheet of paper and indicate question number.
- 3) The application must be signed and dated by the applicant.

**INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED**

**I. CLAIM HISTORY**

- 1)  **LOSSES** Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss. **Complete our supplemental claims form for each loss/claim.**
- 2) **If you have no claims, initial here:** \_\_\_\_\_
- 3) Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim?  Yes  No. **If yes**, give dates, allegations and disposition of each claim or suit on our supplemental claims form for each loss/claim

**II. INFORMATION:**

- 1) School Name: \_\_\_\_\_
- 2) Primary Contact Person: \_\_\_\_\_
- 3) Title: \_\_\_\_\_
- 4) Email Address: \_\_\_\_\_ 5) Phone #: \_\_\_\_\_
- 6) Website: \_\_\_\_\_
- 7) Business Address: \_\_\_\_\_
- 8) City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- 9) Requested Coverage: Professional Liability (check  one)  Claims-made  Occurrence
- 10) Requested Effective Date: \_\_\_\_\_ 11) Retro Date: \_\_\_\_\_

**III. REQUESTED LIMITS:** (check  one)\*:

- \$100,000/\$300,000  \$200,000/\$600,000  \$250,000/\$750,000  \$500,000/\$1,000,000  \$1,000,000/\$3,000,000  
 \$1,000,000/\$6,000,000  \$1,300,000/\$3,900,000 (\*NY only)  \$2,000,000/\$6,000,000 (\*VA only)

**IV. TRAINING PROGRAM DETAILS:**

**1. Program/Operation:** Describe the following:

Type of program/operation	Length of Program	Total Hours (Classroom + Clinical)	Total Clinical Hours Only

Type of program/operation	Length of Program	Total Hours (Classroom + Clinical)	Total Clinical Hours Only

2. **Student Population:** Describe the following information (historical, current, and projected):

Total Number of Faculty and Students	Year _____	Year _____	Current Year _____	Projected Next 12 Months
Students Enrolled				
Faculty				
Staff				
Other (specify):				
Other (specify):				
<b>Total # of Individuals</b>				

3. **Revenues:** Indicate the revenues for following (historical, current, and projected):

Total \$ Revenues Description (list types)	Year _____	Year _____	Current Year _____	Projected Next 12 Months
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
<b>Total \$ Revenue</b>	\$ total	\$ total	\$ total	\$ total

**V. PATIENT CARE :** (check (✓) all that apply. *if questions are Not Applicable check (✓) N/A*):

- 1) Do faculty members provide direct patient care?       Yes     No     N/A
- 2) Do students have direct patient contact?               Yes     No     N/A
- 3) If yes to (1) or (2), describe how many patients have been cared for in each of the past 2 years?

\_\_\_\_\_

\_\_\_\_\_

- 4) If yes to (2), describe how patient care is supervised? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 5) If yes to (2), describe specifics of supervision including (1) faculty:student ratios and (2) supervision by others:

\_\_\_\_\_

\_\_\_\_\_

**VI. WORK SETTING:** Are students participating in any of the following: (check (✓) all that apply)

- |  |
|--|
| <input type="checkbox"/> Surgery/Invasive Procedure(s) <input type="checkbox"/> Medication Administration<br><input type="checkbox"/> Medical Record Documentation <input type="checkbox"/> Direct Hands-On Patient Care <input type="checkbox"/> Observation<br><input type="checkbox"/> OTHER (please describe): |
|--|

- 1) If yes to **any** of the above **WORK SETTING** descriptions, then describe:

\_\_\_\_\_

\_\_\_\_\_

**VII. LOCATION OF CLINICAL ROTATIONS**

<input type="checkbox"/> <b>School Owned Facility</b> Number of Beds: _____
<input type="checkbox"/> <b>Non-School Owned Facility</b> Name and Location of Facility: _____ Number of Beds: _____

1) If clinical rotations take place in a **Non-School Owned Facility** please describe facility, *if Not Applicable state N/A*:

---



---

2) If the facility is a **Non-School Owned Facility**, is there a written contract in place with a mutual indemnification and hold harmless agreement?  Yes  No  N/A

3) Are the following submitted to the **Non-School Owned Facility** (check (✓) all that apply)

- |   |                              |
|---|------------------------------|
| <input type="checkbox"/> Marketing Materials        | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Student Application        | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Program Overview Materials | <input type="checkbox"/> N/A |

**VIII. RISK MANAGEMENT**

1) Check (✓) here  if students are required to take a patient safety and/or risk management course.

2) Check (✓) here  if the school has ever been the subject of a reprimand or disciplinary action or refused accreditation or had accreditation suspended or ever been the subject of any ethics investigation at local state, or national level. If so, please attach a separate sheet with full particulars.

3) Check (✓) here  if the school has ever been denied, cancelled or refused renewal of professional liability insurance coverage. **NOTE: MISSOURI RESIDENTS DO NOT RESPOND TO THIS STATEMENT**

**IX. HISTORICAL PROFESSIONAL LIABILITY INSURANCE INFORMATION:** Please provide past policy information as requested.

1) Does your organization require the faculty to carry their own professional liability insurance?  Yes  No

If yes, specify the minimum limits required: \_\_\_\_\_ Each Person \_\_\_\_\_ Total Limits

2) Do you require written proof of this coverage?  Yes  No

3) Are students covered under either: (a) School's policy?  Yes  No **OR** (b) Faculty's policy?  Yes  No

4) **List all Professional Liability policies** for each of the past five years. Begin with the current policies on the top line.

If Claims Made (CM), provide retroactive date:

Policy Period	Insurer	Limits	Premium	CM (w/ Retro Date) or Occurrence

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS

APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

**THE EARLIEST EFFECTIVE DATE FOR WHICH A POLICY MAY BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.**

**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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** 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.

**NOTICE TO COLORADO APPLICANTS:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA 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.

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

**NOTICE TO LOUISIANA APPLICANTS:** 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.

**NOTICE TO MAINE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MINNESOTA APPLICANTS:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NOTICE TO NEW JERSEY APPLICANTS:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK 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 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.

**NOTICE TO OHIO APPLICANTS:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO OREGON 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:** 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.

**NOTICE TO VERMONT APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Name of Agent: \_\_\_\_\_ License #: \_\_\_\_\_

Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_